

Health Care

... .. Task

Force mtg.

6-4-90 ...

Drue:

The Health Care Cost Containment Cost Task Force will meet again on July 11 at 9:00 a.m. The meeting is planned for all day, but just one day.

Intentions are to have a report prepared by Dave Gray which will lay out the scope of the problem the task force is trying to deal with. It should include such items as:

- a list of providers of insurance
- a list of the individuals covered by state insurances
- a list of services provided
- possible, given time, a list of the utilization of services

In general, where the money is coming from and to whom it's being paid.

With this information, the task force hopes to more clearly identify their objective and course of future meetings.

At today's meeting, as at yesterday's, the task force discussed involving the providers, retirees and other insureds in the process through "public hearing" type meetings. They hope to have these early in the process (ie: August/September).

Mark Boyer and the woman from medicaid are forming a subcommittee to gather information on medicaid services provided.

Greg O'Claray is going to look into getting information on wellness programs and their effectiveness. The task force would like to consider making a recommendation that the bargaining units be allowed to use wellness programs as part of their bargaining, and that the state consider implementing such a program at least on a test basis.

GP -
share with Peg.

J²

OFFICE OF THE PRESIDENT

MEMBER

TENTH ALASKA LEGISLATURE
ELEVENTH ALASKA LEGISLATURE
TWELFTH ALASKA LEGISLATURE
THIRTEENTH ALASKA LEGISLATURE
FOURTEENTH ALASKA LEGISLATURE
FIFTEENTH ALASKA LEGISLATURE
SIXTEENTH ALASKA LEGISLATURE



SENATOR TIM KELLY

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JUNEAU, ALASKA 99811
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ANCHORAGE, ALASKA 99521
(907) 561-7612

May 30, 1990

MEMORANDUM

To: All Members
Health Care Cost Containment Task Force

From: Dave Gray, Staff 

Re: Agenda for the June 4 meeting of the Task Force.

Attached is a proposed agenda for this first meeting in the extended life of the Task Force. I view this meeting as a planning meeting. Thus the agenda is organized as a recap of what the Task Force has done and results thereof, what has transpired legislatively and otherwise since our January 31 report, and then picking up on issues and options for long term cost containment that require further work.

Item one will be an update of the current employee and retiree health plans' experience. I.C. is a holdover issue from last fall when the Task Force sought an A.G. opinion on this matter.

Item two is some preliminary information on both health care provider demographics and state health care expenditures of all types.

Item three is legislative health care issues that were before the current session that were related in part to activities of the Task Force.

The fourth item is a update of federal activities that may impact health care costs to the state (medicaid/medicare) and influence costs of the employee/retiree plans.

The identified long range containment options is a listing from the January 31, report. Dor. Seiler will give a briefing on wellness programs; what they are and how they work. I have included V.F., Reduction of cost shifting, for the uninsured Alaska health care cost issue. This issue was added to the Task Force charge in the extending resolution.

Page 2
Agenda memo

The final item should give an important result for this meeting. It should provide the scope, direction and time frame (targets at least) for the work and deliberations of the Task Force.

As in the past, this agenda is open for additions of new considerations, or deletions of old for that matter. It should be expected that members of the audience will desire to address the Task Force on our goals and objectives.

HEALTH CARE COST CONTAINMENT TASK FORCE

AGENDA

June 4 & 5, 1990 Meeting
Anchorage

- I. Review of Task Force actions and work effort, including
 - A. Experience of active employees' health plan.
 - B. Experience on retirees' health plan.
 - C. Legal parameters for applying cost containment provisions to retirees' health plan: Virginia Ragle, Asst. A.G. *apply to future retirees or make sure there is no diminishment of benefits.*
- II. Nature of Alaska's health care industry and government health care expenditures.
- III. Review of legislative issues and actions.
 - A. SB 254, health insurance pooling.
 - B. SB 550, utilization review standards.
 - C. Effects of uninsured Alaskans' health care, HB 581.
- IV. Federal activities.
- V. Identified long range cost containment options.
 - A. Self-insured plan options.
 - B. Pooling concepts.
 - C. Health care purchasing groups.
 - D. Provider payment schedules.
 - E. Trusts.
 - F. Wellness programs: Don Seiler (see attached vitae).
 - G. Reduction of cost shifting.
- VI. Work Plan.
 - A. Schedule.
 - B. Consulting, other research resources, public involvement.

Proposed Work Plan
Health Care Cost Containment Task Force
March 1990- Feb.1991

Objectives:

To review and recommend additional ways to reduce health care costs or cost shifting under active / retiree health plans , workers compensation plans, medicade programs, and the uninsured Alaska population.

1. Continue to monitor experience and costs of active and retiree State health plans.
2. Complete the investigation and make recommendations on the long term effect of establishing provider payment and utilization standards and associated methods of review. *How you will be the review*
3. Complete the investigation of the potential savings of implementing wellness programs for State health plans.
4. Review and recommend additional cost containment techniques that would favorably impact health care expenditures in Alaska. *Management*
State ex. & retiree
5. Continue to review and recommend financing alternatives for State health care plans.
6. Monitor and report impact of State or Federal health care related mandates to Legislature.
7. Assess the effect of the underinsured/uninsured residents in Alaska on private or Government health plans. Make recommendations on corrective and appropriate solutions.
8. Study the availability, accessibility, quality and pricing appropriateness of health care for Alaskans. Determine total health care expenditure and services demographics in Alaska.
9. Review the cost and benefits of State subsidized health care facilities. Evaluate economies and deficiencies of the health care delivery system.
10. Determine the feasibility and savings of implementing cost containment provisions in the State retirees health plan. Examine the advantages of verifying retiree (dependents) health plan enrollment and eligibility.

*all
State
funded*

P-file
Drue:

7/11/90

RE: Health Care Cost Containment Task Force meeting 7/11/90.
Next meeting will be Sept. 20 & 21 most probably.

Mike _____ on teleconference

Pat Hopcheck cover handout 1 on Utilization Reports of the first quarter.

First Pat had Bev Hodges (Registered Nurse with 15 years critical care experience, who along with one other nurse, does precertifications), explain Aetna's precertification process. If certification is denied by them, there is an appeals process. For the appeal, the request is sent to Connecticut to Aetna's home office. This process generally takes 2-3 days--the longest she recalls is 2 weeks. Outpatient precertification is done by VHS at the first level (these doctors are not employed by Aetna). Emergencies do not go through precertification process. Approximately 6% are denied initially and 14% are "managed second opinions."

Outside travel for medical help has had only 3 claims.

Pat Hopcheck covered handout "1" on Utilization Reports of the first quarter. These are claims paid during the quarter and reflect some claims filed in December but paid in January 1990. Approximately 75% were thought to be incurred after January 1. In the future, will look at claim histories as well.

Duncan asked if 8.1% decrease in payments reflect what Malik would have expected for the changes instituted in the health care plan by the task force. Yes, but first quarter is too early to know for sure. 2nd quarter data will be completed by some time in August--about 30 days from now.

Duncan--is there a savings? Their not sure yet.

Concern was expressed that the Vision Services Plan (VSP) ^{may} be putting some operators out of business. Why must VSP approve the lens grinding shop?

Dave Gray -- expressed concern that the lag time in reporting (ie: 2 months plus) in paid claims retards ability to recognize trends early. However, the plan can't be adjusted in mid-year anyway.

Zeros in estimated savings means there were no denials for this service.

Mike _____ via teleconference discussed Retiree Health Plan and diminishment of Benefits. The most important contributor to savings are 1) precertification and 2) managed second opinion which together account for 4% of the 7% savings.

Boyer asked if we could foresee reduction in monthly premiums in the future due to the savings measures enacted so far. Response was that the actuarial forecast of a 10-12% annual increase may be changed. However, the employer contribution rate for 1991 is set, as is the PERS Board 1992 rates -- which represents 30% of benefits.

Greg O'Claray moved to endorse implementation of changes in handout 2 and Boyer 2nd the motion.

The Alaska Health Care Expenditure Study (handout 2). Which employers offer health insurance plans is directly related to underwriting guidelines (ie: 10 or more employees and the underwriter would have to look at each individual separately as a health risk--however if moved this up to 50 the insurers could better estimate the risk). The higher the underwriting guidelines, the fewer employers would offer insurance plans.

Boyer asked to see a union/nonunion break out of employers offering plans. He also wants a breakout of uninsured/underinsured by industry (ie: does the fishing industry have a greater % under/uninsured?) I would suspect they are more apt to be uninsured since so many are seasonal workers.

In handout 2, page 6 -- these numbers are neither adjusted for inflation nor reflect increased utilization. The data doesn't appear to compare apples to apples to me.

Bruce Cummings commented that he now knows infinitely more about insurance than when we began the Task Force, but still feels we don't know why the costs have gone up so dramatically. Response was that this information would be very difficult to compile. However, Malik is trying to look at hospital fixed costs, malpractice, perhaps new equipment.

Jeff Malik--see handout 3: Thinks the task force should consider subcommittees on: 1) Buying power of the state; 2) Under/uninsured Greg suggested also looking at recommending a wellness program which would include preventative and well child care as suggested by Karen Perdue.

Subcommittees were assigned as follows:

Under/uninsured -- Karen Perdue, Jeff Malik and Dave Gray

Wellness programs -- Nevarre (chair if he agrees, otherwise Duncan may ask you to chair it); Pearce; O'Claray; Huff; Don Hitchcock(?) who was not there today. This committee will look into finding out the effectiveness of wellness programs other states or companies may have instituted and perhaps suggest a control group within the state. Juneau already has one in place.

Buying Power of the State -- Duncan, Cummings, Boyer and Karen Perdue, Michelle Castanedo.

7/11/90

(3)

Post-It™ brand fax transmittal memo: 7671		# of pages	1
To	Dave, Gray	From	Dale, Stalin
Co.	San Kelly	Co.	San Francisco
Dept.		Phone #	465-4766
Fax #	561-3102	Fax #	465-4748

PROPOSED WORK PLAN
HEALTH CARE COST CONTAINMENT TASK FORCE
MARCH 1990 - FEBRUARY 1991

OBJECTIVES

To review and recommend additional ways to reduce or limit health care costs and cost shifting under active/retiree health plans, state funded health programs and the uninsured Alaska population.

1. Determine total health care expenditures and services demographics in Alaska.
2. Monitor and report impact of State or Federal health care related mandates to Legislature.
3. Continue to monitor experience, costs and financing of active and retiree State health plans. Review and recommend additional cost containment or management techniques that would favorably impact health expenditures for State employees and retirees.
4. Complete the investigation and make recommendations on the long term effect of establishing provider payment and utilization standards and associated methods of review.
5. Complete the investigation of the potential savings of implementing wellness programs for State health plans.
6. Assess the effect of the underinsured/uninsured residents in Alaska on private or Government health plans. Make recommendations on corrective and appropriate solutions.
7. Study the availability, accessibility, quality and pricing appropriateness of health care for Alaskans.
8. Review the cost and benefits of State subsidized health care facilities. Evaluate economies and deficiencies of the health care delivery system.

7/10/90

Alaska State Legislature



SENATOR JIM DUNCAN

P. O. BOX V JUNEAU, ALASKA 99811-3100
(907) 465-4766

COMMITTEES:
FINANCE
VICE CHAIR —
HEALTH EDUCATION
& SOCIAL SERVICES
BUDGET & AUDIT
BANKING &
ECONOMIC
DEVELOPMENT

July 9, 1990

MEMORANDUM

To: All members
Health Care Cost Containment
Task Force

From: Dave Gray, Staff

Enclosed is the agenda and associated reports for the July 11 meeting.

The expenditure study is somewhat incomplete. Remaining from the original work plan goals is a better fix on municipal health care expenditures and employee numbers, hospital/physician bad debt and charity estimates, and estimates of the Alaskan private sector health care coverage and associated numbers. None the less, a lot of detailed information on the Alaska health care provider system and health care programs has been accumulated. And more is forthcoming to better complete the total picture.

The first quarter review of the state plan will also have an analysis by the state's consultant, Touche Deloitte. Note that page 49 of the Aetna report has some recommendations on reporting and evaluations.

The memorandum on the state retiree health plan is per the discussion at the last Task Force meeting.

Item 4 on the agenda is a continuation of the discussion on the Task Force's objectives and work plan. In conjunction, there will be an effort to schedule a public hearing process for this work.

There are other areas of Task Force interest (e.g. federal program impacts, uninsured question, etc.) which should be discussed in regard to future scheduling and work effort.

PROPOSED AGENDA

STATE OF ALASKA
HEALTH CARE COST CONTAINMENT TASK FORCE

WED. , JULY 11, 1990, 9:00 AM
ANCHORAGE

1. REVIEW ALASKA HEALTH CARE EXPENDITURES STUDY
2. REVIEW FIRST QUARTER AETNA UTILIZATION REPORT
(actives, retirees)
3. COST MANAGEMENT PROVISIONS FOR RETIREE HEALTH PLAN
4. LONG RANGE HEALTH CARE COST MANAGEMENT TECHNIQUES
 - A. Provider payment and utilization schedules
 - B. Voluntary Pooling
 - C. Self Funding Health Care Delivery
 - D. Access and delivery of health care
 - E. Alternate care settings
 - F. Provider and Utilization review monitoring
 - G. Wellness programs
5. OLD/NEW BUSINESS

7/11/90 (2)

ARTHUR J. GALLAGHER & CO.

Sen. Jim Duncan, Chairman
State of Alaska Health Care Cost Containment
Task Force
Box V
Juneau, AK 99811

Dear Jim,

Enclosed you will find the preliminary study of Health Care Expenditures in Alaska as requested by the Task Force.

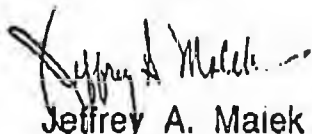
It is important to note that this is a preliminary report based on information and methodology outlined in the appendix section.

We are compiling additional information regarding Health Care Expenditures in Alaska such as provider market shares, more detailed demographics and Health Care Expenditure projections.

We would like to acknowledge Dave Grays' help and persistence in gathering the information needed to produce this report.

If there is any additional data or analysis you or the task force need, please advise.

Sincerely,



Jeffrey A. Maiek
Area Assistant Vice President

Chart1

ARTHUR J. GALLAGHER & CO.

PERCENT OF U.S. HEALTH CARE EXP. BY SOURCE OF PAYMENT 1989

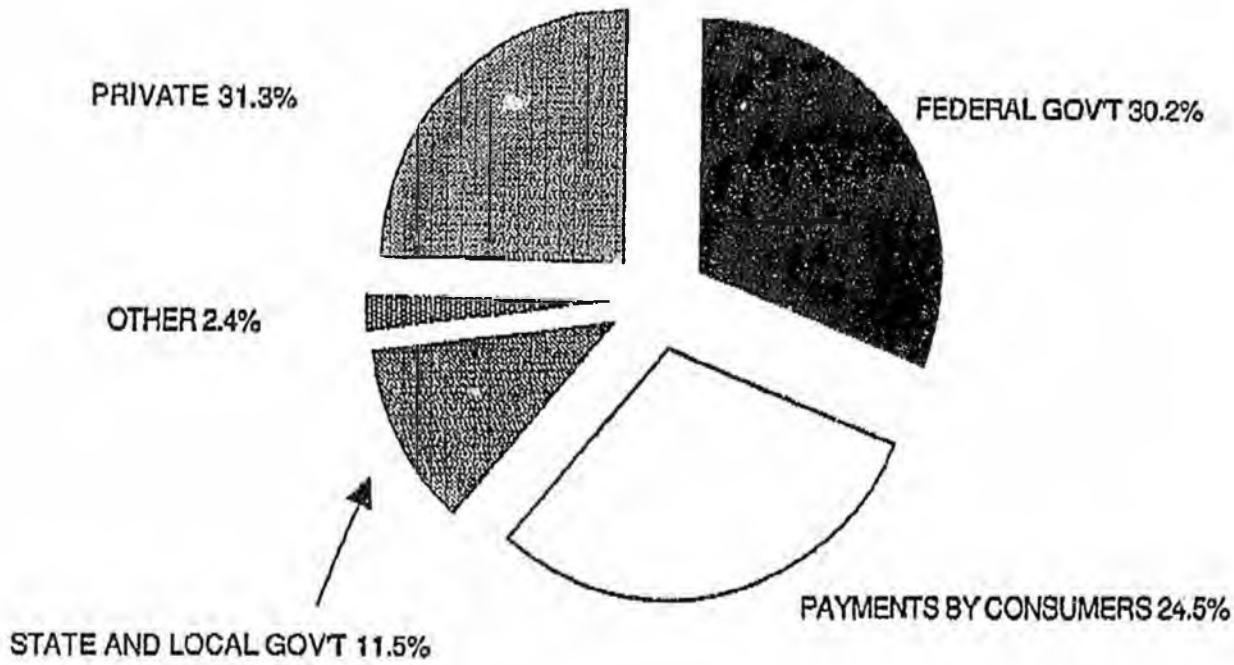


Chart2

ARTHUR J. GALLAGHER & CO.

PERCENT OF ALASKA HEALTH CARE EXP. BY SOURCE OF PAYMENT 1989

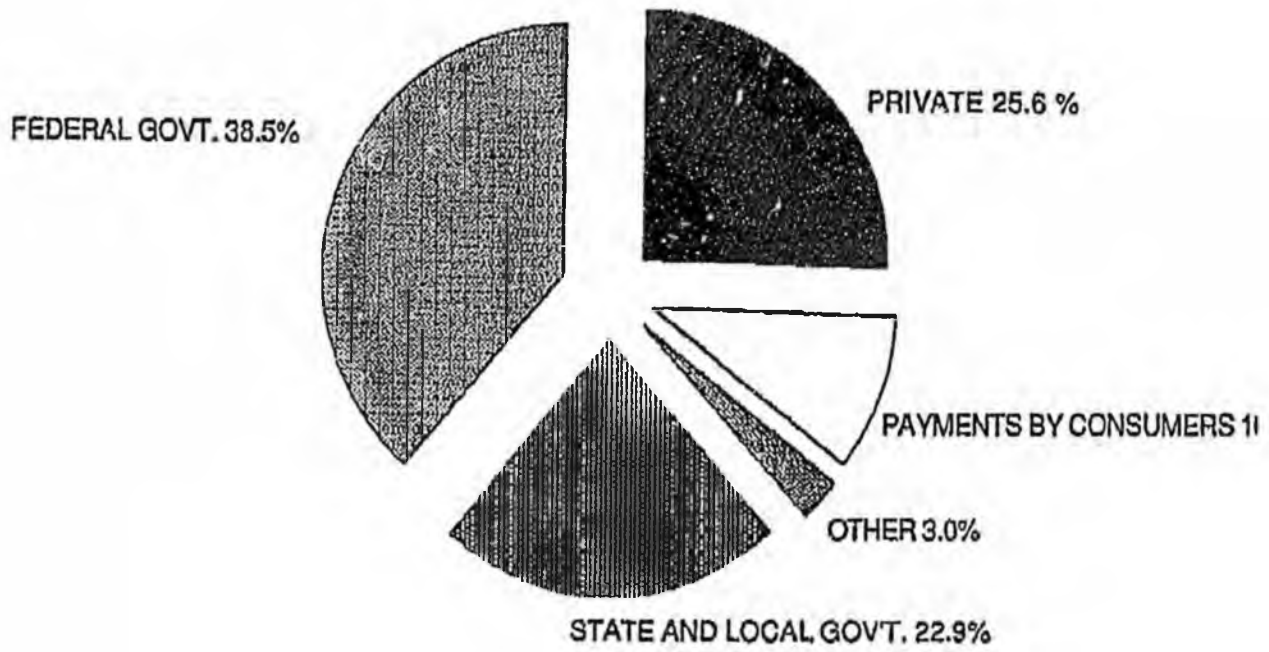


CHART 3

ARTHUR J. GALLAGHER & CO.

STATE OF ALASKA HEALTH CARE EXPENDITURES 1979 VS 1989

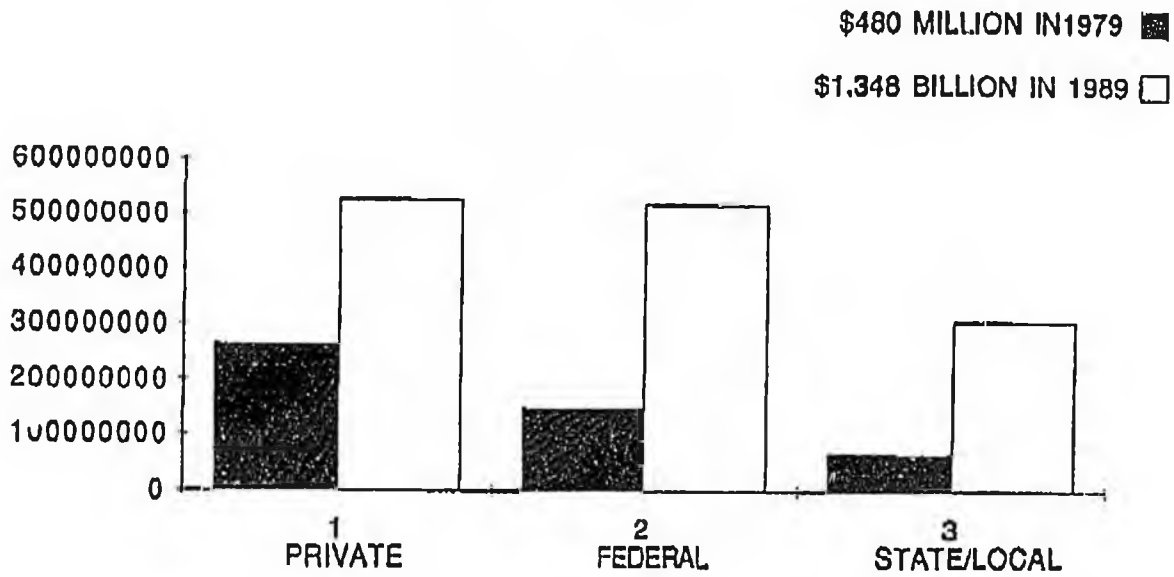
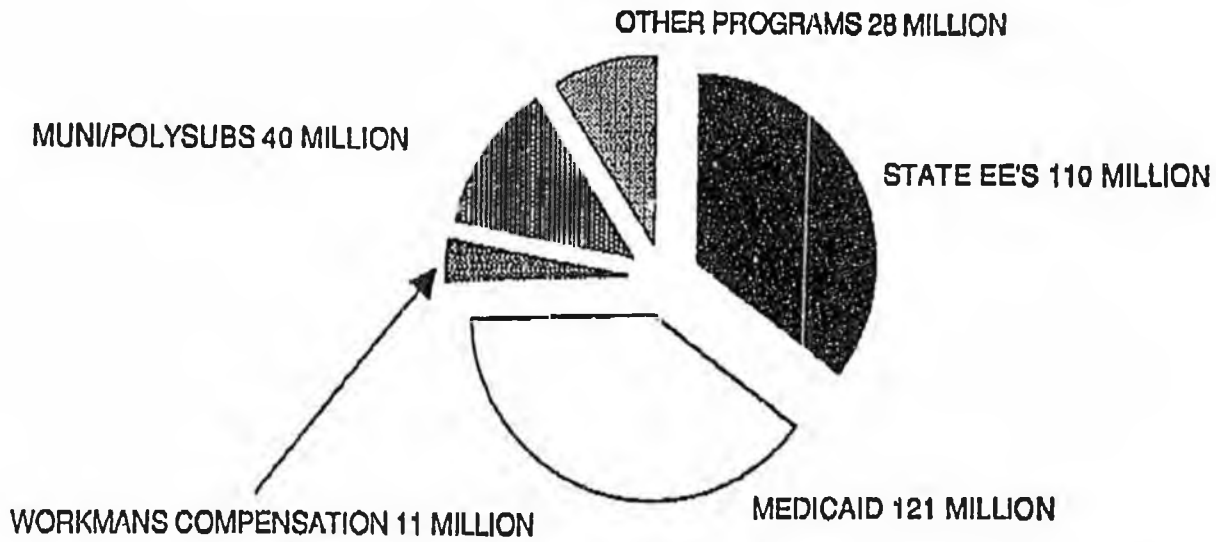


Chart4

ARTHUR J. GALLAGHER & CO.

1989 STATE OF ALASKA HEALTH CARE EXPENDITURES FOR STATE AND LOCAL GOVT.



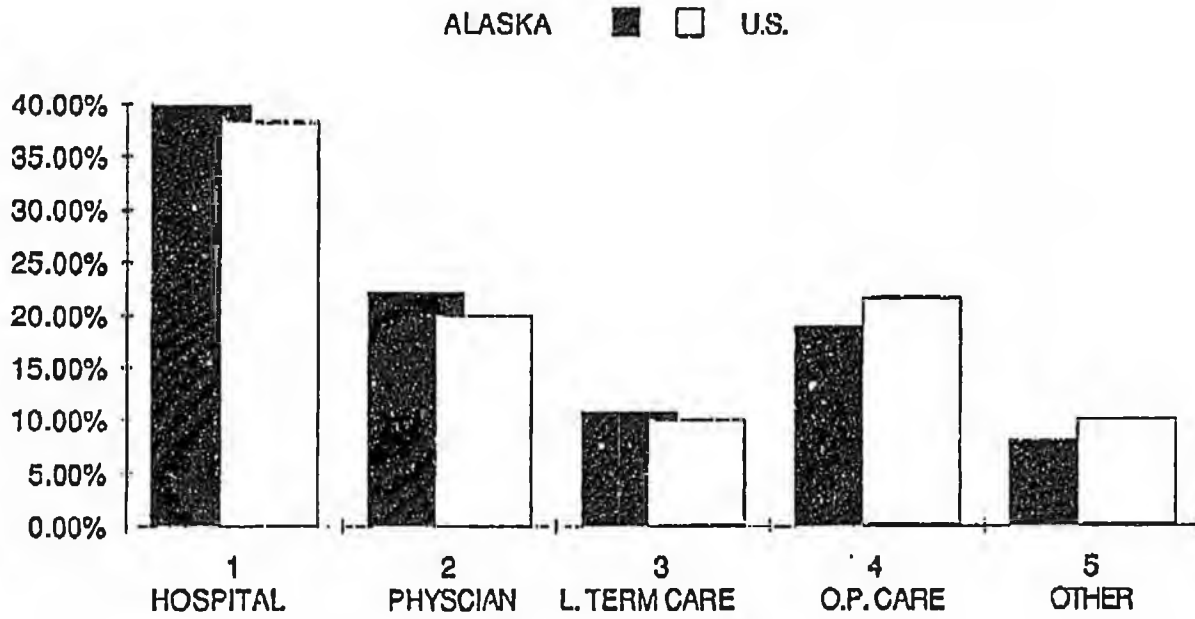
TOTAL STATE GOV'T HEALTH CARE EXPENDITURES

1989-----310 MILLION

CHART 5

ARTHUR J. GALLAGHER & CO.

ALASKA VS U. S. HEALTH CARE EXPENDITURES BY SERVICE CATAGORY
1989



ARTHUR J. GALLAGHER & CO.

STATE OF ALASKA

	1979	1984	1989
POPULATION	401,000	522,000	534,000
H.C. EXPD.	\$480 MILL.	\$710 MILL.	\$1.34 BILL.
PER.CAP. H.C. EXP.	\$1197.00	\$1360.00	\$2524.00

ARTHUR J. GALLAGHER & CO.

STATE OF ALASKA
HEALTH CARE EXPENDITURES STUDY

METHODOLOGY

Due to the nature of this study it was necessary to compile statistics from numerous sources in order to supplement our existing health care data base.

This information while current and credible had to be manipulated to assure that the parameters and time periods were similar.

The evaluation and reporting of data is according to standard statistical analysis procedures in order to assure accuracy within +/- 10%.

THE INFORMATION CONTAINED IN THIS REPORT IS OUR INTERPELLATION OF THE DATA ON HEALTH CARE EXPENDITURES IN ALASKA AND THE UNITED STATES.

SOURCES

Battelle Study
Dept. of Health and Social Services*
Division of Retirement and Benefits*
Division of Insurance*
State Demographer*
Institute of Social and Economic Research (Univ. of Alaska)
Health Care Financing Administration (HCFA)
U. S. Bureau of The Census

*State of Alaska

ARTHUR J. GALLAGHER & CO.

DEFINITION OF HEALTH CARE PAYORS

STATE / LOCAL GOVERNMENT (Alaska)

State employees/retirees and dependents
Political subdivisions employees/retirees and dependents
Medicaid recipients (50%)
Workmans Compensation medical benefits
Community based health programs
Pioneer Homes
General relief medical

FEDERAL

Federal employees / retirees and dependents
Indian Health Services
CHAMPUS
Veterans Administration
Medicare
Medicaid (50%)

PRIVATE

Private pay
Private health insurance

DIRECT CONSUMER PAYMENTS

Health care costs paid directly by residents to providers
(deductibles, co-payments, uninsured procedures)

MEMORANDUM

State of Alaska

TO: Dave Gray
 Health Care Cost Containment
 Task Force
 Senator Kelly's Office
 Alaska State Legislature

DATE: July 9, 1990

FILE NO.:

THRU: Sally Smith *[Signature]*
 Director
 Division of Retirement and
 Benefits
 Department of Administration

TELEPHONE NO.: 465-4470

FROM: *[Signature]* Michael B. Coughlin
 Deputy Director
 Division of Retirement and
 Benefits
 Department of Administration

SUBJECT: Retiree Health Plan

The Task Force asked that I provide a list of items that might be incorporated into the retiree health plan to assist in cost containment. These items were to be selected from the list of negotiated changes made to the active employee's health plan.

Assistant Attorney General Virginia Ragle and I have reviewed the changes that were negotiated in an attempt to identify those which were least likely to be considered a diminishment of benefits. The items listed below are those that are considered best suited, cost effective and least disruptive to the retiree when considering the legal implications.

1. Addition of a precertification program for all inpatient services and selected outpatient services. This program would include benefit reductions for services received that are not certified as medically necessary.
2. Addition of a managed second opinion program in which a second opinion MAY be required for selected services. The program would require precertification and entail benefit reductions for non-compliance.
3. Addition of 100% coverage for care received in a skilled nursing facility in lieu of an inpatient hospital stay. This benefit must also be precertified to avoid reductions in benefits.

Services in a skilled nursing facility for any reason is not currently covered by the plan.

4. Addition of travel benefits for the purpose of receiving services in a location other than the retiree's local area. The plan would cover the total costs of all services received (not including ancillary and miscellaneous expenses) PLUS the cost of transportation to another

Most important - 4 of 7 savings

Dave Gray

-2-

July 9, 1990

area up to the usual, customary, and reasonable costs for the same services in the retiree's local area.

The cost of travel is currently not covered when services can be provided in the retiree's local area.

5. **Addition of a mail order prescription drug program in addition to the normal benefits available for prescriptions.** A \$5.00 co-payment would be required for any brand name prescription. Generic drugs would be paid in full. The same co-pays of \$5.00 for brand name drugs and \$0 co-pay for generics would be implemented for all other prescriptions.

Retirees currently pay 20% of any brand name prescription and do not have access to a mail order plan.

6. **Addition of a requirement that the retiree reimburse the carrier for covered medical expenses in the event that a settlement is received from a third party such as another insurance carrier.** This situation normally occurs only in the event of injuries received in an accident and would prevent retirees from having medical claims paid both by the plan's carrier and collecting an additional sum from another liable party.

You are probably aware that the current monthly retiree medical premium is \$243.98. The premiums for all retirees (public employees, teachers, judges and elected officials) are paid for from the retiree funds which are supported in most part by both employee and employer contributions.

It is estimated that if the above changes were implemented effective January 1, 1991, premiums could be decreased by a minimum of 7%.

Although the Plan Administrator could legally make such changes to the plan should you, the Task Force, wish to endorse them, I recommend that such changes **NOT** be made unless both the Public Employees and the Teachers Retirement Boards support them. Both boards will be meeting in mid-October, at which time a proposal could be discussed.

MBC/ksl

cc: Frank S. Baxter, CPA
Commissioner
Department of Administration

Gary Bader
Deputy Commissioner
Department of Administration

Virginia Ragle
Assistant Attorney General
Department of Law



Backgrounder

BG059001

States Information Center
The Council of State Governments
Iron Works Pike
P.O. Box 11910
Lexington, KY 40578-1910
(606) 231-1939

Date: May, 1990
Topic: HEALTH INSURANCE FOR THE UNINSURED
Infokey: Insurance
(NT) Health

CURRENT STATE PERSPECTIVES ON PROVIDING HEALTH INSURANCE TO THE UNINSURED

There are three principal categories of people who cannot obtain health insurance: the unemployed and uninsured, the working uninsured, and the medically uninsurable (those who because of their health condition, cannot get insurance through private carriers). Many who are unemployed and uninsured typically cannot meet state Medicaid requirements. Of these three groups, the medically uninsurable represent a distinct minority, about 2 million total people.

Seventy percent of the uninsured are employed but do not receive health insurance through their place of employment.¹ In addition, 15 million U.S. workers or their dependents lost job-based health insurance in the last decade.² Those employers who cover their employees do so twice -- directly, and indirectly as the costs of the uninsured are factored into private reimbursement rates.³

The uninsured are less likely to see a doctor for routine treatment, probably will not seek treatment for illnesses when they become apparent,⁴ and are more apt to use emergency room care than those with health insurance.⁵ Three quarters of all uncompensated care is given to those who cannot pay.⁵

America's health care system is not particularly cost effective, especially when compared to the system used in Canada. Canada spends roughly \$1,400 per person and 8.5 percent of its gross national product on health care. All Canadians receive health benefits. The U.S. spends \$2,000 per person and 11 percent of its gross national product on a patchwork of programs that does not cover 37 million of its citizens.⁶

*This CSG Backgrounder was compiled by Wayne Hall, Research Assistant, Management and Administration, The Council of State Governments.

Note: *Backgrounder* information is the latest available at the time of publication, but for updates, you should contact the appropriate state or federal agency directly. This material does not represent the position of The Council of State Governments. Information is included based on relevance to the topic. Some material, as noted, is copyrighted and may not be reproduced further without permission of the original publisher. Contact the States Information Center or the writer at CSG.

CSG Backgrounder -- Insurance for the Uninsured

Federal Activity

The Congressional Bipartisan Commission on Health Care -- the Pepper Commission -- recently delivered its proposals to Congress. The commission's proposals would require employers to provide insurance or pay a tax to fund government insurance.

State Activity

States like Connecticut, Florida, Hawaii, Minnesota and Wisconsin have formed risk pools to help insure the medically uninsured.

Florida and Michigan are pursuing innovative programs to insure employees of small businesses. Hawaii has successfully pursued a employer-based health insurance model since 1974. It requires all businesses to offer health insurance and all employees to accept it. New York and Washington provide universal access models that would all residents regardless of their employment status.

A summary of state programs includes:

Arizona: Health Care Group of Arizona

This program offers coverage to businesses with 25 or fewer employees. Plans under the umbrella of the Health Care Group (HCG) are required to contract with the Arizona Health Care Cost Containment System (AHCCCS) which functions like the federal Medicare program.

One plan operating under this Health Care Group is the University Family plan, a managed care product offered in the Tucson area. The Health Care Group administers the plan, providing billing and marketing services to the health care provider. The HCG is currently seeking additional contractors. It has an enrollment of about 820 people. The state does not subsidize any portion of the health insurance. The Health Care Group is expanding its marketing efforts in the state to attract other health insurance plans.

Contact: Gail Gazelle
Acting Project Director
The Health Care Group of Arizona
801 East Jefferson St.
Phoenix, AZ 85034
602/253-9119

CSG Backgrounder -- Insurance for the Uninsured

California: Tucker Health Care Coverage Act

The Tucker Health Care Coverage Act has been passed by the California Legislature and signed by Governor Deukmejian. It creates a statewide network through which employers with five or more employees may provide health care coverage. Employers must pay at least 75 percent of the cost and may pool employees for group rates. Employers may also band together and provide benefits through self-insurance. Lifetime benefits are capped at \$1,000,000 for each insured individual.

Although the original bill contained language establishing tax credits for businesses while authorizing a commission to study various tax incentives, there is some controversy between the governor and the speaker's office over whether the act or the pending commission report will be the final word on tax credits. This disagreement may affect the Jan. 1, 1992 implementation date.

Contact: Ken Tiratira
Office of California State Assembly
Speaker Willie Lewis Brown Jr.
Room 219
State Capitol
Sacramento, CA 95814
916/445-8077

Florida: Florida Small Business Health Access Corporation

The Florida Small Business Health Access Corporation (FSBHAC) is a "nonprofit public service corporation established by the Florida Legislature in 1987 to pool small employer groups into large groups for the purpose of insurance."¹⁰

Originally conceived as a Multiple Employer Trust (MET) whereby employers pool employees for private coverage, the FSBHAC is now a non-profit organization that administers an extensive health insurance program on behalf of Florida businesses with two to nine employees. Currently FSBHAC administers programs for 800 employees and 165 businesses.¹¹ FSBHAC was created in May, 1989.

To be eligible for coverage, employees may not have had insurance in the previous six months. FSBHAC executes a contract with health care providers, arranges for the collection of premiums, develops eligibility criteria and handles billing for health care services. FSBHAC claims that the corporation is able to offer very small businesses in the state rates 25 percent below individually-negotiated private insurance premiums.¹²

Contact: Ree Sailors
Director
FSBHAC
235 East Virginia
Tallahassee, FL 32301
904/681-9914

CSG Backgrounder -- Insurance for the Uninsured

Maine: Maine Health Program

The Maine Health Program is the result of recommendations issued by the Special Select Commission on Access to Health Care on February 15, 1989. The special commission was created by the 113th Session of the Maine Legislature. It recommended the following:

- 0 Establishment of a Medicaid buy-in program.
- 0 Partial subsidization of the cost of reinsurance for small employers.
- 0 Tax incentives for a limited period of time to encourage small employers to offer health insurance.

This program provides comprehensive statewide "Medicare-type" health insurance for adults and children with incomes ranging from 95 to 125 percent of federal poverty levels. It employs a sliding scale standard to determine patient expenses.

Contact: Charlene Rydell
Chair
Joint Standing Banking and
Insurance Committee
State House Station
Augusta, ME 04333
207/289-1314

Massachusetts: Health Security Act of 1988

All Massachusetts residents will have access to health insurance by 1992. Among the features of the Massachusetts program, small business group insurance will be available for firms with six or fewer employees. Tax credits will be offered this year for businesses with 50 or fewer employees who have not offered insurance in the previous three years. By 1992, most businesses will be required to contribute to a state administered medical insurance trust fund. Employers already contributing to employee health insurance costs will be allowed a tax deduction equal to the contribution.

Three groups will be exempt from the law: businesses with five or fewer employees, businesses in the first year of operation and businesses that are self-insured. The Massachusetts program provides for a Hardship Fund to pay for the cost of an employers insurance liability exceeding five percent of the company's gross revenue.

The act also provides for cost hospital containment measures designed to limit charges to private payors and reduce private payor contributions to hospital bad debt and free care pools.

CSG Backgrounder -- Insurance for the Uninsured

Contact: Mary Yeaton
Consumer Liaison
Department of Medical Security
600 Washington Street
Suite 2000
Boston, MA 02111
(617) 727-8300

Michigan: Health Care Access Project

The Michigan Health Care Access Project is currently funded by the Michigan Legislature at \$400,000 through 1990, an increase of 100 percent since last year.¹⁴

The Michigan Health Care Access Project has three goals:

- 0 Improve health care access for individuals relying on government assistance.
- 0 Offer care to individuals who qualify under the financial rules for Medicaid assistance, but do not meet other criteria for such assistance.
- 0 Offer care to individuals who have lost their Aid to Families with Dependant Children (AFDC) benefits because they are newly-employed.¹⁵

The third goal is being met through a "1/3 share program" under which individuals who work for employers that do not offer health insurance may obtain health insurance. Under the formula, employers pay 1/3 of the cost of the health insurance premium, employees pay 0 to 66 percent of the cost of the premium (using a sliding scale formula based on income) and the state, using the Last Resort Fund, contributes the rest. Individuals earning 200 percent of the federal poverty level pay a full 2/3 of the cost of the plan.

One of the purposes of the plan is to encourage poor people to keep jobs once they get them. Those with jobs but no health benefits are two and one-half times more likely to quit those who have jobs with health benefits.¹⁶

Contact: Vernon Smith, Ph.D.
Director
Bureau of Program Policy
Medical Services Administration
Michigan Department of Social Services
300 South Capital
P.O. Box 30037
Lansing, MI 48909
517/335-5000

CSG Backgrounder -- Insurance for the Uninsured

New Jersey: New Jersey Health Care for the Uninsured Project

This project is partially funded by the Robert Wood Johnson Foundation through a grant that is scheduled to terminate December 31, 1990.¹⁷ New Jersey has allocated an additional \$6 million in state money to expand the project for small businesses.

The program has two parts: a reinsurance program to reimburse insurance companies that offer discount premiums and a dependent coverage program that will offer direct state subsidy of health insurance premiums for dependents. New Jersey operates an uncompensated care payment fund, which it hopes to use for the reinsurance program. This fund was created in 1986 and reauthorized in 1989.

Contact: Pam Dixon
Department of Health
John Fitch Plaza
CN 360, Room 601
Trenton, NJ 08635
609/292-8773

New York: UNY*Care

The UNY*Care proposal arose from a New York Academy of Medicine report in 1988 which advocated universal medical coverage.¹⁸

This program is in the conceptual stage and would insure every New Yorker under 200 percent of the federal poverty level. It is being proposed by the New York Commissioner of Health. Scheduled to be introduced in the next session of the New York General Assembly, this measure also would target children for health care insurance and address the long-term care needs of the state's citizens.¹⁹ In all probability the general assembly will not adopt the total package. New York has pursued pilot projects to insure the employed uninsured through their place of employment. Features of the UNY*Care program include:

- 0 "One card" coverage offering standardized benefits for NY residents.
- 0 Single payer responsible for billing and payment, uniform reimbursement.
- 0 Mandatory employer provided health care meeting a minimum benefit level.
- 0 Subsidized health insurance for individuals meeting income requirements.²⁰

These requirements would expand Medicaid and employer-based coverage and implement a one-payer system for universal coverage to provide:

CSG Backgrounder -- Insurance for the Uninsured

- 0 Statewide preventative care from birth to the age of 17.
- 0 Primary care for low-income individuals.
- 0 Catastrophic benefits statewide.

The central feature of UNY*Care is interposing a single payer (the state) between multiple third party health care payers and providers to buy and regulate the delivery of health care.²¹

New York proposes to finance UNY*Care by restructuring \$1.1 billion in bad debt, the charity care pool fund, and an unemployment insurance surcharge on employers. Employers that provide health insurance can avoid the surcharge. Insurance companies and employers will have a stop/loss of a maximum of \$25,000 per person.²²

The pilot programs work through a state subsidy offered to Blue Cross/Blue Shield as an incentive to extend basic health insurance to businesses with 20 or fewer employees, or, to individuals not eligible for Medicaid.²³ In order to participate, individuals and families must:

- 0 Have a gross household income at or below 200 percent of federal non-farm poverty levels.
- 0 Not be receiving medical care provided under the NYS Medical Assistance program.
- 0 Not be eligible for Medicare.
- 0 Be uninsured for a period of time. This does not apply to the newly unemployed.

Contact: Gary Fitzgerald
Executive Director
Council on Health Care Financing
845A Legislative Office Building
Albany, NY 12247
518/455-2067

Oregon: Senate Bill 27

Senate Bill 27 was approved July, 1989, and signed by the governor. This legislation must receive several waivers from the Health Care Financing Administration (HCFA), the federal agency responsible for administering Medicaid, to become operational. Oregon would like to begin operation July 1, 1990, but expects difficulty in receiving the waivers from HCFA. A Senate reconciliation waiver, currently moving through Congress, would order the HCFA to waive certain requirements in Oregon.²⁴

This program expands state Medicaid to cover people below 100 percent of federal poverty standards. Those earning above the federal poverty level will

CSG Backgrounder -- Insurance for the Uninsured

be insured through an employer mandate. It also would prioritize health care offered under the plan. For instance, immunizations would be given a higher priority than kidney transplants. All medical services would be identified and prioritized by an 11-member commission of health care professionals and consumers.

Once the list of health care priorities is established, an actuarial firm will determine cost of each service. The legislature will then start at the top of the list and work its way down. The idea is to offer access to basic health care. Since the program would alter not only the financial standards for eligibility, but also the type of services offered under Medicaid, it is being resisted strongly by the HCPA, according to Gibson.²⁵

Contact: Mark Gibson
Executive Assistant to the
President of the Senate
State Capitol, Room S203
Salem, OR 97310
503/378-8173

Washington: Basic Health Plan

Washington's Basic Health Plan operates in Seattle, Spokane, Tacoma and on the Olympia Peninsula. It is available to people with annual incomes at or below 200 percent of the federal poverty level. The plan includes the poor and working uninsured unable to qualify for Medicaid. Individuals with incomes exceeding 200 percent of the federal poverty level are eligible to use the plan provided they pay 100 percent of the cost of the premium.²⁶

The office of the Washington Basic Health Plan oversees the administration of the program including selection of a benefits package, identification of cost-saving mechanisms and negotiation with health care providers wishing to participate in the plan. The state subsidizes a portion of the insurance premium from state general fund taxes. The amount of the state subsidy is based on a sliding scale targeted to an individual's income.²⁷ The entire program is exempted from state insurance laws. The plan is subject to sunset review in 1992.

Contact: Featherstone Reid
Office of Finance Management
Insurance Building, Room 100
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Olympia, WA 98504
206/753-1949

7/11/90

(4)

DISCUSSION DRAFT

Dear-----,

The Health Care Cost Containment Task Force has been reviewing the costs and availability of health care in ALASKA since March 1989. And has identified a number of cost management techniques for short and long range results. The short range measures have already been implemented and are showing positive results.

In order to properly evaluate long range health care cost management techniques the Task Force will be holding public hearings to gather additional information and perspectives.

I would like to extend an invitation for (you, your group) to attend and provide us with your input. The hearings will be held during September 1990.

Enclosed is some background information on the health care economy in Alaska. You will receive additional information as to the specific concern before the Task Force.

If you have any questions or comments please contact Dave Gray at 465-3822 or myself.

Sincerely,

WELLNESS PROGRAMS

Employer-sponsored wellness programs aim to improve and maintain the health of employees, and controls the rising cost of employer-provided health insurance by reducing the number of employee claims.

The varied wellness program offerings by employers range from education classes or seminars to complex fitness programs in sophisticated company exercise facilities. The goal of these programs is to encourage healthier life-styles for employees. "Wellness" concentrates on the "whole health" and well-being of the individual employee, and wellness programs promote better health habits to positively affect both the employee's work life and private life. The introduction of wellness programs in the workplace complements the more traditional health care system that treats illnesses as and after they occur. Generally, the programs are employer funded because few group insurance plans offer preventive programs.

Programs may involve smoking cessation, stress management, employee fitness, annual physicals, health risk appraisals, nutrition, weight control, hypertension, and back care. Overall health promotion programs may incorporate substance abuse programs, such as employee assistance programs, and screening programs for high blood pressure, early cancer detection, AIDS, glaucoma, and diabetes.

The challenge is to design a wellness/fitness program that matches the health care needs of the employees with the resources available. It doesn't have to be an elaborate, expensive program to be effective. There are several options available varying in cost and complexity that can bring positive, long-term health benefits. The first step is to evaluate the types of health problems most prevalent among employees, what staff resources are available to design and oversee the program, and how much money there is to spend.

Until recently, evidence suggests that there is very little concern on the part of the sponsors for measuring the effectiveness of their programs, particularly from a financial perspective. The sponsors' commitment to health promotion program evaluation and to the development of efficient evaluation strategies to measure their program returns is essential.

Recent Tax Reform Act provisions (which emphasize the economic viability of corporate investments as opposed to their tax sheltering characteristics) and increased competitive pressures from foreign corporations only serve to underscore the necessity for saving from program investment to be documented with sound empirical evidence.

FEDERAL GOALS

In listing its national health and disease prevention objectives for the year 2000, the federal government has targeted as its goal an increase in the proportion of worksites offering employer-sponsored fitness program.

According to a U.S. Department of Health and Human Services survey, nearly 66 percent of worksites with more than 50 employees had at least one health promotion activity in 1987, with smoking topping the popularity list.

Recognition of the need for wellness programs has also been acknowledged by the federal government in legislation. Although the law has provided for health services for federal employees since 1946, in 1986 the government clarified that the "health services" prescribed include physical fitness programs and facilities designed to promote and maintain employee health. As the nation's largest employer, the federal government actively encourages federal agencies to implement wellness programs to promote good health.

WELLNESS PROGRAMS

RESULTS

As reported by **Business Insurance**, April 17, 1989

Between 1986 and 1987, the "Taking Care" program introduced by Travelers in 1986 reported savings of 0.33 to 0.77 on doctor visits per employee; measured health behavior improvements in smoking, alcohol consumption, seat belt use, relaxation practices, exercise and eating habits; a decrease in the projected death rate per 1,000 employees of 0.17 per year; and a perception of the program as a valued health care benefit for 81% of the employee population.

As reported by **The American Journal of Health Promotion**, November/December 1989

Between 1985 and 1986, the "TriHealthalon", a wellness voluntary program introduced by General Mills, Inc. reported that the percent of participants that smoke decreased from 21 to 16 percent. Seat belt usage increased from 44 to 71 percent. Improvements in lifestyle habits among TriHealthalon participants during the first two years of the program suggests it has increased lifestyle and health awareness among the participant group. It was also determined that there is a \$5.10 to \$3.90 payback for each dollar spent in developing the TriHealthalon program.

As reported by **Health Care Promotion**, November 1989

- o DuPont's program, which includes fitness facilities, smoking cessation, health education, and counseling, has resulted in a 37 percent reduction in heart attacks among salaried employees and an 18 percent reduction among hourly employees.
- o Health-care expenses for San Diego's school employees and firefighters average \$548 a year less per employee for fitness program participants than nonparticipants.
- o SpeedCall Corporation's smoking cessation and fitness program resulted in a 50 percent decrease in the number of insurance claims among employees who quit smoking.
- o At Tenneco, the average medical claim for a non-exercising female employee was more than twice the average for women who participated in the in-house exercise program (\$1,536/\$639). For men, the average claim for non-exercisers was \$1004 compared with \$562 for exercisers.
- o Lockheed Missiles and Space Company saved an estimated \$1 million in life insurance costs through its wellness program.
- o Absenteeism among exercising employees at Lockheed was 60 percent lower than for nonexercisers-and turnover was 13 percent lower among regular exercisers.
- o A daily before-work aerobics class significantly reduced the number of on-the-job injuries among Marriott Hotel's housekeepers.
- o Control Data in Minneapolis now pays \$1.8 million less for health care each year because of its ten-year Stay Well program.
- o Based on the results of its two-year wellness program AT&T estimates it will save \$10 million or more in 10 years just from reducing the risk of cancer and heart disease among its workforce.
- o A five-year study of Johnson & Johnson's Life for Life program revealed that hospital costs for participating employees were half that of nonparticipants. The reduction of hospital-related medical insurance costs alone more than pays for the \$200 per employee spent annually on the wellness program.

WELLNESS PROGRAMS

RESULTS - CONTINUED

- o For every dollar spent on its Stay Alive & Well program, which is provided to all employees, spouses, and retirees, Blue Cross-Blue Shield of Indiana saves \$1.45 million in health-care costs.

As reported by Topics in Total Compensation, Summer 1989

Control Data Corporation has been keeping track of both specific employee health habits and medical costs, and is one of the few corporations that has conclusively matched the two. Control Data found that employees who smoke a pack of cigarettes a day generate 18% higher medical claims than nonsmokers; sedentary employees have claims 14% higher than individuals who exercise vigorously at least three times a week for a minimum of 20 minutes at a time; hypertensive and overweight (30% over ideal) employees have costs 11% higher for each group than healthy employees; and using seat belts less than 25% of the time while driving translates into 13% higher medical claims costs than when they are used more frequently.

As reported by Health Care Promotion, November 1989

- o People who don't exercise have 36% higher health care costs and 54% longer hospital stays than people who exercise. Overweight people have 7% higher health care costs and 85% longer hospital stays than people who are thin. Companies with wellness/fitness programs report that employees who participate in these programs are absent half as much as nonparticipants, and their morale and productivity is markedly higher than nonparticipating employees.
- o Bank of America's Corporate Health Programs called "Be Your Best" includes featured the monthly "Challenge" along with other components, which included the following: take your children, spouse or friend out for a walk at least three times a week; eat one generous serving of fresh fruit or salad, drink six glasses of water; and drink two glasses of low-fat milk every day. Complete a seven-minute stretching exercise every workday for a month. Every workday for a month find one cartoon or joke that made you laugh and share it with someone else at work. In the year before Bank of America trained 250 managers in their pilot program, stress-related workers' compensation claims in that region dropped from \$124,000 to \$29,000.
- o Bank of America's workers' compensation claims related to back injury exceed \$1.3 million annually, where the claims are concentrated in only a few departments. These departments were targeted for a program developed and implemented by a registered physical therapist on staff. The results after the first six months were substantial, not only in the reduction of the number of injuries, but also in days lost and workers' compensation claims. If the trends continue, Bank of America expects 245 fewer workdays will have been lost and \$44,000 will have been saved in workers' compensation claims for the full year.
- o 24% of Bank of America's employees smoke. (The national average is 27%.) Studies have found that smokers cost their companies at least \$400 more annually than nonsmokers in terms of increased medical care, absenteeism, etc. A pilot group of employees using an intervention program designed for physicians to help their patients stop smoking called "Quit for Life" enabled 22% of the pilot group to stop smoking.

As you can see the companies referred to above report significant savings in health care costs and marked improvements in employee productivity, morale, absenteeism, and retention. There are many low cost methods to provide employee health education, individual assistance, early detection, and exercise programs.

FEDERAL LEGISLATION

The Omnibus Reconciliation Act of 1989 (OBRA 1989). Congress passed on November 22, 1989 and signed into law on December 19, 1989. Designated as P.L. 101-239. A number of significant provisions affect employee benefits. Most are contained in Title VII of the Act, which is called the Revenue Reconciliation Act of 1989, of which the following is a summary:

Employee Stock Ownership Plans (ESOPs); changing the method of calculating the Social Security wage base; addition of ERISA Section 502 which levies a civil penalty for a breach of fiduciary duty; interest on employee mandatory contributions to defined benefit plans; quarterly contribution provisions apply on to single-employer defined benefit plans and do not apply to money purchase pensions; annual valuations of defined benefit plans rather than every three years; and the definition of normal retirement age.

This law also contained changes to the health care continuation law, COBRA, the changes follow:

- o **Disabled Employees.**
Effective for plan years beginning on or after December 19, 1989, coverage extends 29 months (from 18 months) for qualified beneficiaries with a disability at the time of termination of employment or reduction in hours of employment. This amends IRC Section 4980(f)(2)(B). The disability could have occurred prior to the qualifying event. In order to be entitled to the extended continuation coverage, the qualified beneficiary must be determined under title II or XVI of the Social Security Act to have been disabled at the time of the termination of employment or reduction in hours. Allowable premium charged to the beneficiary for the 19th through the 29th month from 102% to 150%.
- o **Preexisting Conditions.**
COBRA coverage must be provided if the qualified beneficiary is covered under other health plans that do not provide coverage for pre-existing conditions. This provision is effective for qualifying events occurring after December 31, 1989 and for qualified beneficiaries electing COBRA coverage after December 31, 1988.
- o **Premium Payment.**
Plan administrators may not require any premium payment until 45 days after the qualified beneficiary makes the initial election of COBRA coverage. This provision is effective for plan years beginning after December 31, 1989.
- o **New Definition of Covered Employee.**
Covered employees entitled to COBRA coverage include independent contractors, partners and self-employed individuals covered under a group health plan. This provision is effective for plan years beginning after December 31, 1989.
- o **Dependents' Eligibility.**
Dependents' eligibility for COBRA coverage is extended to a period of 36 months when the employee or former employee becomes entitled to Medicare benefits.

Physician Payment Reform (resource based relative value scale, or RBRVS) restructures the way Medicare reimburses physicians and is designed to contain Medicare's costs for physician payments as well as to reduce the perceived inequities in payment to primary care givers as compared to surgeons and other specialists. Volume performance standards were established. Effective in 1992, physicians will be compensated by Medicare based on RBRVS which will be phased in over a five year period. During the phase-in period, the physician will be paid in a combination of current payment methods and the fee schedule.

FEDERAL LEGISLATION

On Wednesday, December 13, President Bush signed into law H.R. 3607, the Medicare Catastrophic Coverage Repeal Act of 1989. Designated as P.L. 101-234, The repeal is effective January 1, 1990. Expanded hospital benefits, a new prescription drug benefit, and a cap on out-of-pocket doctor expenses have now been eliminated from the Medicare program. The Medicare surtax, which would have applied in 1989, was retroactively repealed. Congress retained provisions of the Act that improved coverage for certain low-income individuals and protected individuals from being forced into poverty when a spouse must be cared for in a nursing home.

On November 7, 1989, Congress repealed IRC Section 89. On November 11, 1989, President Bush signed the 1989 debt limit legislation into law. The debt ceiling bill essentially repeals the present law regarding nondiscrimination and minimum qualification standards and reinstates nondiscrimination rules in effect before the Tax Reform Act of 1986.

A SURVEY OF THE 101st CONGRESS ON HEALTH CARE LEGISLATION

Metropolitan Life conducted a survey of the priority key issues of the 101st Congress on health care legislation. Virtually all of the Congressional respondents surveyed say they regard health-care as either a "top priority" or "very important." 43% of the legislators surveyed think the nation's health-care system is in "a state of crisis."

Legislators reviewed a list of health care issues of concern to corporations and then name the main issue on the list facing the 101st Congress. For each of the issues listed, respondents were also asked to predict whether some form of related legislation will be enacted over the next two years. The results follow:

	Top Health Care Issues	Chances for Legislation
Long-term care for the elderly	33%	50%
Drug abuse	20%	56%
Modification of existing funding for Medicare catastrophic coverage	14%	35%
Insuring the uninsured	14%	12%
Infant mortality rate	5%	36%

Congress will assign priority to containing health care costs and extending health care coverage to all segments of society. Congress also has an eye on AIDS care research as well as the nursing shortage, Medicare reimbursement to physicians and hospitals, rural health care problems, Medicare/Medicaid funding, prenatal and pediatric care, and medical malpractice and liability.



STATE OF ALASKA

EXPENSE/UTILIZATION SUMMARY ACTIVE EMPLOYEES--1ST QUARTER 1990

Gross Submitted Expenses

1st Quarter 1990 Versus 1989 Quarterly Average	0.0%
1st Quarter 1990 Versus 1st Quarter 1989	-7.5%

Net Paid Expenses

1st Quarter 1990 Versus 1989 Quarterly Average	-9.9%
1st Quarter 1990 Versus 1st Quarter 1989	-12.5%

Hospital Admissions

1st Quarter 1990 Versus 1989 Quarterly Average	-12.3%
1st Quarter 1990 Versus 1st Quarter 1989	-15.3%

Hospital Patient Days

1st Quarter 1990 Versus 1989 Quarterly Average	-22.3%
1st Quarter 1990 Versus 1st Quarter 1989	-33.5%

Average Hospital Length Of Stay

1st Quarter 1990 Versus 1989 Quarterly Average	-10.9%
1st Quarter 1990 Versus 1st Quarter 1989	-23.0%

(Note: ALOS For 1989=6.4 days; 1st Q 1989=7.4; 1st Q 1990=5.7)

Outpatient Surgical Procedures

1st Quarter 1990 Versus 1989 Quarterly Average	+5.1%
1st Quarter 1990 Versus 1st Quarter 1989	+3.1%

Inpatient Surgical Procedures

1st Quarter 1990 Versus 1989 Quarterly Average	+2.1%
1st Quarter 1990 Versus 1st Quarter 1989	-5.9%

PER EMPLOYEE PLAN EXPENSE BY TYPE OF CARE
1ST QUARTER 1990 VS. 1ST QUARTER 1989

Inpatient Hospital	-18.6%
Inpatient Surgical	-8.3%
Outpatient Surgical	+5.7%
Outpatient Physician (Non-Surgical)	-3.8%
Chiropractic	-33.9%
Outpatient Mental/Nervous Substance Abuse	-12.0%

HOSPITAL INPATIENT PRECERTIFICATION

<u>Condition</u>	<u>Confinements Certified</u>	<u>Confinements Not Certified</u>	<u>% Not Certified</u>
Medical/Surgical	950	93	8.9
Maternity/Pre-Natal	272	11	3.8
Adolescent Psychiatric	15	12	44.4
Alcohol Abuse	33	6	15.3
All Other Psychiatric/ Substance Abuse	143	10	6.5
Total	1413	132	8.5%

OUTPATIENT PRECERTIFICATION

	<u>Total Certified</u>	<u>Total Not Certified</u>	<u>% Not Certified</u>
Managed 2nd Opinion	124	13	6.4%
Outpatient Precert	323	22	9.5%

ESTIMATED POPULATIONS OF ALASKANS WHOSE HEALTH CARE
COSTS ARE DIRECTLY, INDIRECTLY, OR PARTIALLY PROVIDED FOR BY
THE STATE

<u>Employee/retiree/other</u>	<u>Dependents</u>	<u>Totals</u>
1. State Active Employees		
13,070	18,925	31,995
2. Retirees (State, Muni, School) (PERS & TRS).		
10,500	9,800	
Up to 60% reside in state.		
6,300	5,900	12,200
#. Local Govt. Active Employees (PERS).		
13,600	18,400	32,000
4. Teacher Actives (TRS).		
8,200	11,000	19,200
5. Univ. of Alaska.		
3,035	3,204	6,239
6. Corrections (prisoners).		
2,516		2,516
7. Medicaid/Medicare Eligibles. Division of Medical Assistance		
41,000		41,000
		<u>41,000</u> (144,150)

Notes:

- A. Some of the people appearing in item 2 will be counted in item 7.
- B. Estimates of dependents in items 3 and 4 assume that the groups exhibit the same age and sex characteristics as in group

STATE OF ALASKA
 Family Demographics
 March 1990

<i>Age</i>	<i>Employee Only</i>	<i>EE + spouse 1</i>	<i>EE + child</i>	<i>EE + 2 or more children</i>	<i>EE + spouse + 1 child</i>	<i>EE + spouse + 2 or more children</i>	<i>Total</i>
16-20	17	1	1	0	1	0	20
21-25	196	37	15	7	21	10	286
26-30	569	170	52	35	96	151	1073
31-35	855	283	82	93	227	544	2084
36-40	996	382	129	156	328	928	2919
41-45	866	355	152	155	350	917	2795
46-50	594	410	96	90	297	478	1965
51-55	379	360	29	22	144	147	1081
56-60	219	222	12	3	55	34	545

242

	TOTAL	4829	2357	572	562	1536	3214	13070
81-85	0	1	0	0	0	0	0	1
71-80	2	2	0	0	0	0	0	4
66-70	22	24	1	1	1	3	1	52
61-65	114	110	3	0	0	14	4	245

STATE OF ALASKA
Spouse Demographics
March 1990

<i>Age</i>	<i>Number</i>
15-20	4
21-25	91
26-30	492
31-35	1180
36-40	1610
41-45	1487
46-50	1094
51-55	600
56-60	306
61-65	147
66-70	43
71-80	24
81-85	5
86+	3
TOTAL	7086

STATE OF ALASKA
Dependent Demographics
March 1990

<i>Age</i>	<i>Number of Dependent Children</i>
0-5	2250
6-10	2895
11-15	2969
16-19	2346
20-23	1299
24+	80
TOTAL	11839

ASSOCIATION OF ALASKA SCHOOL BOARDS

316 W. 11th St. • Juneau, Alaska 99801-1510 • (907) 586-1083

February 7, 1990

Senator Tim Kelly
Alaska State Legislature
P.O. Box V
Juneau, Alaska 99811

RE: SCHOOL DISTRICT HEALTH CARE COSTS

Dear Senator Kelly:

Annually, when we conduct our Salary and Benefit Surveys, we ask questions relating to health care costs for various categories of employees.

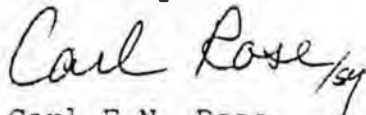
The enclosed information shows, by district, what kind of premiums are currently being paid for single employees and employees with families.

In the past we have asked for total health care costs for teachers and administrators, but have overlooked asking that question for *classified employees*. We are quickly surveying districts so that we can provide you with that additional piece of information -- to complete the overall picture of total health care costs for *all* employees. Hopefully we can get that information back from districts fairly quickly.

Like you, we have a real interest in helping school districts find ways to control the rapidly increasing costs of health insurance. We are also concerned that any proposed solutions will actually provide a real benefit to districts.

If we can assist you further in this regard, please don't hesitate to let us know.

Sincerely,



Carl F.N. Rose
Executive Director

enc

STATEWIDE: SCHOOL DISTRICT MEDICAL EXPENDITURES FOR TEACHERS

DISTRICT	REGION	ADM	FTE CERT STAFF	MED PREM S	MED PREM F	TOT DISTRICT COST
ADAK	SW	655	43	\$1,873		\$71,200
ALASKA GATEWAY	INT	458	40	\$1,274	\$3,848	\$103,182
ALEUTIAN REGION	SW	112	13	\$2,200	\$6,000	\$36,200
ANCHORAGE	SC	37,176	2,355	\$2,438		\$5,981,395
ANNETTE ISLANDS	SE	419	39	\$1,266	\$3,835	\$90,124
BERING STRAIT	NW	1,261	128	\$760(SI)	\$1,986(SI)	\$554,000
BRISTOL BAY	SW	249	25	\$1,260		\$31,500
CHATHAM	SE	321	39	NA	NA	
CHUGACH	SC	94	14	\$1,392	\$4,217	\$45,052
COPPER RIVER	INT	591	45	\$4,680	\$4,680	\$210,600
CORDOVA	SC	425	35	\$1,303	\$3,949	\$113,767
CRAIG	SE	227	17	NA	NA	
DELTA/GREELY	INT	897	60	\$1,883	\$5,691	\$276,000
DILLINGHAM	SW	445	40	\$1,931	\$5,489	\$151,804
FAIRBANKS	INT	13,696	863	Self Insured	\$4,069	\$3,511,256
GALENA	INT	145	19	NA	NA	\$47,947
HAINES	SE	331	32	\$1,894(SI)	\$5,692(SI)	\$156,000
HOONAH	SE	255	19	\$1,883	\$5,690	\$59,348
HYDABURG	SE	100	11	\$1,368(SI)	\$2,748(SI)	\$61,884
IDITAROD	INT	389	40		\$4,300	\$164,160
JUNEAU	SE	4,575	295	\$3,324		\$980,580
KAKE	SE	183	19	\$4,320(SI)	(SI)Self Insure	\$79,920
KASHUNAMIUT	SW	165	17	\$3,109(SI)	\$6,011(SI)	\$47,000
KENAI	S	8,438	569	\$4,529(SI)	\$4,529(SI)	\$2,432,277
KETCHIKAN	SE	2,498	170	\$1,820	\$5,018	\$608,677
KLAWOCK	SE	203	16	\$537(SI)	\$1,871(SI)	\$40,935
KODIAK	SW	2,341	160	\$1,693	\$5,129	\$481,182
KUSPUK	SW	384	45		\$5,235	\$237,958
LAKE & PENINSULA	SW	357	41	\$1,392	\$4,218	\$104,282
LOWER KUSKOKWIM	SW	2,768	241	\$2,210(SI)	\$2,210(SI)	\$552,500
LOWER YUKON	SW	1,264	125	\$911	\$2,763	\$165,479
MAT-SU	SC	8,744	508	\$4,664	\$4,664	\$2,391,840
NENANA	INT	194	18	\$1,524	\$4,392	\$53,998
NOME	NW	753	51	\$1,319	\$4,164	\$*69,936
NORTH SLOPE	NW	1,246	145	(SI)Self Insure	\$2,550	\$400,000
NW ARCTIC	NW	1,632	123	\$1,800	\$1,800	\$235,000
PELICAN	SE	41	6	\$1,783	\$5,691	\$25,640
PETERSBURG	SE	657	46	\$1,873	\$5,676	\$156,445
PRIBILOF	SW	151	13	\$1,876	\$5,691	\$26,663
RAILBELT	INT	336	30	\$1,873	\$5,676	\$110,516
SANDPOINT	SW	152	15	\$1,399	\$2,400	\$29,312
SE ISLANDS	SE	502	52	\$1,465	\$4,424	\$139,863
SITKA	SE	1,685	106	\$1,660	\$5,000	\$398,664
SKAGWAY	SE	146	12	\$1,896	\$5,700	\$51,552
ST. MARY'S	SW	111	12	\$1,265	\$3,542	\$28,548
SW REGION	SW	461	59	\$1,265	\$3,834	\$152,537
TANANA	INT	93	8	\$1,922	\$5,876	\$42,036
UNALASKA	SW	181	17		\$4,533	\$78,874
VALDEZ	SC	750	61	\$1,460(SI)	\$4,424(SI)	\$231,056
WRANGELL	SE	518	41	\$1,260	\$3,828	\$121,705
YAKUTAT	SE	129	14	\$1,873	\$5,676	\$49,726
YUKON FLATS	INT	338	37	(Self Insured)	(SI)	\$432,000
YUKON-KOYUKUK	INT	512	49		\$4,780	\$214,620
YUPIIT	SW	306	28	\$1,560	\$3,000	\$44,208
						\$22,980,946 *

LEGEND

$\Sigma = 7,026 \rightarrow$

- ADM-Student Enrollment (Average Daily Membership—a half time student counts as .5)
- FTE CERT STAFF-Number of certificated staff (teachers) using Full Time Equivalency
- MED PREM S-Indicates the Medical Premium paid annually by the district for a Single individual
- MED PREM F-Indicates the Medical Premium paid annually by the district for a Family
- TOT DISTRICT COST-Total costs to the district for medical insurance coverage of this group of employees
- NA-Not Available SI-Self-Insured * NOTE: Figure does not include Chatham, Craig school districts.

STATEWIDE: SCHOOL DISTRICT MEDICAL EXPENDITURES FOR ADMINISTRATORS

DISTRICT	REGION	ADM	FTE ADMIN	SUPT MEDICAL PREMIUM	CO MEDICAL PREMIUM	PRIN MEDICAL PREMIUM	TOT MEDICAL COSTS
ADAK	SW	655	6	\$5,888	\$3,900	\$4,000	\$14,688
ALASKA GATEWAY	INT	462	7	\$3,832	\$3,832	\$3,832	\$21,999
ALEUTIAN REGION	SW	112	5	\$1,873	\$5,620		\$16,701
ANCHORAGE	SC	37,176	119	\$2,438	\$2,438	\$2,438	
ANNETTE ISLAND	SE	419	5	\$2,750	\$7,670	\$5,101	\$15,501
BERING STRAIT	NW	1,261	24	\$1,986	\$1,986	\$1,986	\$30,700
BOSTON BAY	SW	249	3	\$4,440	\$1,260	\$1,260	\$6,960
CHATHAM	SE	321	6	\$5,600	\$5,600	\$5,600	\$22,400
CHUGACH	SC	94	7	\$1,905	\$4,548		\$7,498
COPPER RIVER	INT	591	6	\$4,680	\$4,680	\$4,680	\$20,080
CORDOVA	SC	425	4	\$3,949	\$3,949	\$3,949	\$15,796
CRAIG	SE	227	3	\$3,025	\$2,605		\$8,635
DELTA/GREELY	INT	897	6	\$1,884	\$1,784	\$1,884	\$32,520
DILLINGHAM	SW	445	8	\$1,931	\$1,931	\$1,931	\$33,240
FAIRBANKS	INT	15,696	52	\$3,767	\$3,767	\$3,767	\$390,831
GALENA	INT	145	3	\$2,770	\$3,854	\$2,854	\$6,624
HAINES	SE	331	3	\$1,884			\$17,085
HOONAH	SE	255	4	\$1,784	\$1,784	\$1,784	\$1,262
HYDABURG	SE	100	3	\$4,104		\$4,104	\$8,208
IDITAROD	INT	389	12	\$4,320	\$4,320		\$51,840
JUNEAU	SE	4,575	19	\$3,240	\$3,240	\$3,240	\$61,560
KAKE	SE	183	3	\$4,320	\$4,320		\$12,960
KASHUNAMIUT	SW	165	2	\$1,902		\$1,902	\$3,804
KENAI	SC	8,438	50	\$4,529	\$4,529	\$4,529	\$322,946
KETCHIKAN	SE	2,498	14	\$1,995	\$1,995	\$1,995	\$69,236
KLAWOCK	SE	203	2	\$3,948		\$3,948	\$7,896
KODIAK	SW	2,341	17	\$1,693	\$1,693	\$1,693	\$59,914
KUSPUK	SW	INFO NA	0				
LAKE & PENINSULA	SW	357	22	\$4,224	\$4,224	\$4,224	\$31,904
LOWER KUSKOKWIM	SW	2,768	34	\$2,210	\$2,210	\$2,210	\$75,140
LOWER YUKON	SW	1,264	19	\$2,763	\$2,763	\$2,763	\$35,571
MAT-SU	SC	8,744	38	\$4,664	\$4,664	\$4,664	\$177,232
MEHANA	INT	194	3	\$4,388	\$4,388	\$4,388	\$13,164
NOME	NW	753	7	\$4,164	\$4,164	\$4,164	\$27,179
NORTH SLOPE	NW	1,246	27	SELF INSURE	SELF INSURE	SELF INSURE	\$110,000
NORTHWEST ARCTIC	NW	1,632	31	\$1,920	\$1,920	\$1,920	\$49,920
PELICAN	SE	41	1	\$1,873			\$1,873
PETERSBURG	SE	657	3	\$5,676		\$2,972	\$11,620
PRIIBLOF ISLANDS	SW	151	2	\$1,883		\$1,883	\$5,690
RAILBELT	INT	336	4	\$5,676	\$1,873	\$5,676	\$18,997
SAND POINT	SW	152	2	\$1,399		\$4,200	\$5,599
SITKA	SE	1,685	8	\$3,688	\$5,000	\$3,688	\$32,376
SKAGWAY	SE	146	1	\$1,872			\$5,700
SOUTHEAST ISLAND	SE	502	7	\$1,465	\$1,465	\$1,465	\$23,340
SOUTHWEST REGION	SW	461	12	\$959	\$959	\$959	\$32,899
ST. MARY'S	SW	111	2	\$2,750		\$3,542	\$6,292
TANANA	INT	93	1	\$4,218			\$4,218
UNALASKA	SW	181	2	\$4,533			\$7,253
VALDEZ	SC	750	6	\$4,424	\$4,424	\$4,424	\$32,425
WRANGELL	SE	518	4	\$1,260		\$1,260	\$14,290
YAKUTAT	SE	129	2	\$5,676		\$5,676	\$11,352
YUKON FLATS	INT	338	9	\$4,644	\$4,644	\$4,644	\$37,152
YUKON/KOYUKUK	INT	512	19	\$4,380	\$4,380	\$4,380	\$83,220
YUPIIT	SW	306	7	\$3,100	\$1,600	\$3,100	\$12,600
							\$2,125,890 *

Σ = 666

LEGEND

ADM—Student Enrollment (Average Daily Membership—a half time student counts as .5)
 FTE ADMIN—Number of administrators using Full Time Equivalency—a half time administrator counts as .5
 MEDICAL PREMIUM—Indicates the Medical Premium paid annually by the district for SUPERINTENDENTS, CENTRAL OFFICE staff, and PRINCIPALS
 TOT MEDICAL COST—Total costs to the district for medical insurance coverage.

* NOTE: Figure does not include Anchorage, KuspuK school districts.

STATEWIDE: SCHOOL DISTRICT MEDICAL EXPENDITURES FOR CLASSIFIED STAFF

DISTRICT	REGION	ADM	FTE CLASS	MED PREM S	MED PREM F	TOT DISTRICT COST
ADAK	SW	655	32.80	\$1,922		
ANNETTE ISLANDS	SE	419	23.00	\$1,512	\$4,584	
BERING STRAIT	NW	1,261	209.72	\$816	\$2,404	
BRISTOL BAY	SW	249	13.87	\$1,332		
CHATHAM	SE	321	32.00	\$2,520	\$6,960	
COPPER RIVER	INT	591	25.50		\$4,920	
CORDOVA	SC	425	20.00	\$1,560	\$4,728	
DELTA/GREELY	INT	897	35.00	\$1,932	\$5,892	
DILLINGHAM	SW	445	25.50		\$4,200	
FAIRBANKS	INT	13,696	425.50		\$3,768	
GALENA	INT	145	10.00	\$1,523	\$4,595	
HAINES	SE	339	9.00	\$1,884		
HOONAH	SE	255	13.50	\$1,512		
HYDABURG	SE	100	10.35	\$1,920		
IDITAROD	INT	389	49.61		\$4,296	
JUNEAU	SE	4,575	143.85		\$3,288	
KAKE	SE	183	12.33		\$4,392	
KENAI	SC	8,438	320.80		\$3,600	
KETCHIKAN	SE	2,498	96.00	\$1,620	\$4,812	
KLAWOCK	SE	203	7.00	\$1,308		
KODIAK	SW	2,341	132.02	\$1,608	\$4,872	
KUSPUK	SW	384	41.25	\$588		
LAKE & PENINSULA	SW	357	42.66	\$1,392		
LOWER KUSKOKWIM	SW	2,768	212.02			
LOWER YUKON	SW	1,264	102.00	\$1,764	\$5,256	
MAT-SU	SC	8,744	328.32		\$4,980	
NENANA	INT	194	9.61	\$1,524	\$4,392	
NORTH SLOPE	NW	1,246	350.00	\$672	\$2,628	
NORTHWEST ARCTIC	NW	1,632	151.00			
PELICAN	SE	41	3.07	\$1,688	\$5,040	
PETERSBURG	SE	657	19.40	\$1,740	\$4,740	
RAILBELT	INT	336	19.06	\$1,872	\$5,676	
SITKA	SE	1,685	46.00	\$1,656	\$4,980	
SKAGWAY	SE	146	6.00		\$5,676	
SOUTHEAST ISLAND	SE	502	67.10	\$1,452	\$4,416	
SOUTHWEST REGION	SW	461	54.00	\$1,260	\$3,840	
ST. MARY'S	SW	111	7.32	\$1,260		
UNALASKA	SW	181	10.80		\$4,536	
VALDEZ	SC	750	54.00	\$1,200	\$3,660	
WRANGELL	SE	518	20.00	\$1,260	\$3,840	
YAKUTAT	SE	129	12.50	\$1,872		
YUKON FLATS	INT	338	44.00		\$2,640	
YUKON/KOYUKUK	INT	512	79.00		\$4,320	
YUPIIT	SW	306	104.00	\$516	\$1,896	

NOT AVAILABLE - CURRENTLY BEING SURVEYED

$\Sigma = 3,780.46$

LEGEND

- ADM-Student Enrollment (Average Daily Membership-a half time student counts as .5)
- FTE CLASS-Number of classified employees using Full Time Equivalency-a half time employee counts as .5
- MED PREM S-Indicates the Medical Premium paid annually by the district for a Single individual
- MED PREM F-Indicates the Medical Premium paid annually by the district for a Family
- TOT DISTRICT COST-Total costs to the district for medical insurance coverage.

NOTE: Bering Strait, LKSD, North Slope are self insured.

TOTAL HEALTH CARE COSTS FOR SCHOOL DISTRICT EMPLOYEES BY CATEGORY

FY 89

DISTRICT	TOT DIST COST ADMIN	TOT DIST COST TCHRS	TOT DIST COST CLASSIFIED	ALL DISTRICT TOT
ADAK	\$14,688	\$71,200	(\$25,201.00)	\$111,089.00
ALASKA GATEWAY	\$21,099	\$103,182	(\$73,185.94)	\$188,366.94
ALEUTIAN REGION	\$16,701	\$36,200	(\$18,605.90)	\$71,506.90
ALEUTIANS EAST				\$180,000.00
ANCHORAGE		\$5,981,395		\$14,508,000.00
ANNETTE ISLANDS	\$15,501	\$90,124	(\$96,315.00)	\$201,840.00
BERING STRAIT	\$30,700	\$554,000	(\$80,027.00)	\$664,727.00
BRISTOL BAY	\$6,960	\$31,500	(\$63,431.31)	\$101,291.31
CHATHAM	\$22,400			\$209,394.91
CHUGACH	\$7,498	\$45,052	(\$30,437.18)	\$87,887.18
COPPER RIVER	\$28,080	\$210,600	(\$91,323.56)	\$330,003.56
CORDOVA	\$15,796	\$113,767	(\$1,552.68)	\$131,115.68
CRAIG	\$8,635			\$75,579.49
DELTA/GREELY	\$32,520	\$276,000	(\$177,276.00)	\$485,796.00
DILLINGHAM	\$33,240	\$151,804	(\$129,956.00)	\$315,000.00
FAIRBANKS	\$380,871	\$3,511,256	(\$1,021,757.00)	\$4,913,844.00
GALENA	\$6,624	\$47,947	(\$40,380.00)	\$94,951.00
HAINES	\$17,085	\$156,000	(\$37,240.00)	\$210,325.00
HOONAH	\$1,262	\$59,348	(\$50,661.00)	\$111,271.00
HYDABURG	\$8,208	\$61,884	(\$4,072.00)	\$74,164.00
IDITAROD	\$51,840	\$164,160	(\$171,636.79)	\$387,636.79
JUNEAU	\$61,560	\$980,580	(\$287,276.00)	\$1,329,416.00
KAKE	\$12,960	\$79,920	(\$73,184.00)	\$166,064.00
KASHUNAMIUT	\$3,804	\$47,000	(\$14,526.00)	\$65,330.00
KENAI	\$322,946	\$2,432,277	(\$550,964.00)	\$3,306,187.00
KETCHIKAN	\$69,236	\$608,677	(\$342,710.00)	\$1,020,623.00
KLAWOCK	\$7,896	\$40,935	(\$12,169.00)	\$61,000.00
KODIAK	\$59,914	\$481,182	(\$150,232.00)	\$691,328.00
KUSPUK		\$237,958		\$446,561.12
LAKE & PENINSULA	\$31,904	\$104,282	(\$67,200.19)	\$203,386.19
LOWER KUSKOKWIM	\$75,140	\$552,500	\$ 527,640	1,225,280.00
LOWER YUKON	\$35,571	\$165,479	(\$646,792.00)	\$847,842.00
MAT-SU	\$177,232	\$2,391,840	(\$1,561,419.00)	\$4,130,491.00
NENANA	\$13,164	\$53,998	(\$40,138.00)	\$107,300.00
NOME	\$27,179	\$169,936	(\$37,218.00)	\$234,333.00
NORTH SLOPE	\$110,000	\$400,000	(\$370,809.00)	\$880,809.00
NW ARCTIC	\$49,920	\$235,000	(\$174,938.00)	\$459,858.00
PELICAN	\$1,873	\$25,640	(\$6,870.00)	\$34,383.00
PETERSBURG	\$11,620	\$156,445	(\$81,088.00)	\$249,153.00
PRIBILOF	\$5,690	\$26,663	(\$36,246.90)	\$68,599.90
RAILBELT	\$18,997	\$110,516	(\$49,965.44)	\$179,478.44
SE ISLANDS	\$32,376	\$139,863	(\$6,066.00)	\$178,305.00
SITKA	\$5,700	\$398,664	(\$183,764.33)	\$588,128.33
SKAGWAY	\$23,340	\$51,552	(\$2,036.00)	\$76,928.00
ST. MARYS	\$32,899	\$28,548	(\$42,553.00)	\$104,000.00
SW REGION	\$6,292	\$152,537	(\$65,254.00)	\$224,083.00
TANANA	\$4,218	\$42,036	\$ 46,254.00	92,508
UNALASKA	\$7,253	\$78,874	(\$40,832.00)	\$126,959.00
VALDEZ	\$32,425	\$231,056	(\$150,717.00)	\$414,198.00
WRANGELL	\$14,290	\$121,705	(\$45,368.00)	\$181,363.00
YAKUTAT	\$11,352	\$49,726	(\$24,347.88)	\$85,425.88
YUKON FLATS	\$37,152	\$432,000	\$42,593.31	\$426,558.69
YUKON-KOYUKUK	\$83,220	\$214,620	(\$150,400.04)	\$448,240.04
YUPIIT	\$12,600	\$44,208	(\$100,639.29)	\$165,447.29
	212,291	22951636		\$40,961,368.64

* CLASSIFIED TOTAL IS AN ESTIMATED FIGURE

Total = \$ 41,680,262.64

Total [(# Adm) + (# Tchrs) + (# Class)] = 11,472

University of Alaska

TO: Dave Grey
FROM: Bob Warren
DATE: February 20, 1990
RE: YOUR REQUEST FOR EMPLOYEE BENEFIT PROGRAM INFO

3,035 employees covered in Basic Health Plan.

3,204 dependents covered.

1989 cost/employee/month (\$305.00) = \$11,108,100/year.

STATE EXPENDITURES ON HEALTH CARE SERVICES

	<u>(Millions)</u>
1. Dept. of Health & Social Services.	236.3
2. Elementary & secondary schools.	41.7
3. Dept. of Corrections.	8.0
4. U. of A.	11.1
5. Dept. of Community & Regional Affairs.	5.0
6. Dept. of Administration.(employees).	50.0
7. Dept. of Administration (retirees).	21.0
8. Dept. of Administration.(other).	<u>12.4</u>
	\$385.5

DEPARTMENT OF HEALTH AND SOCIAL SERVICES
DIRECT MEDICAL EXPENSES-FY90

	General Fund	Federal Funds	Other	Total	Recipients Served	Notes
Medicaid Non-facility	25,891.0	25,654.2		51,545.2	16,940	
Medicaid Facilities	46,524.4	46,060.9		92,585.3		
Indian Health Services		9,403.9		9,403.9		
Medicaid - PFD Hold Harmless			1,300.0	1,300.0		
Medicaid - ALB Hold Harmless	1,236.6			1,236.6		
General Relief Medical	6,385.1			6,385.1		
Medicaid State Programs		4,687.1		4,687.1		
Foster Care	390.0			390.0	925 FTE's	Provided by DFYS staff.
Residential Care	73.3			73.3	310	Provided by DFYS staff.
McLaughlin Youth Center	106.4			106.4		
Fairbanks Youth Facility	60.7			60.7		
Nome Youth Facility	7.0			7.0		
Johnson Youth Center	0.5			0.5		
Bethel Youth Facility	23.8			23.8		
Manitlaq - Public Health				0.0		
Nursing	305.3			305.3		
Eye Care	48.7			48.7	1,000	
EMS	124.7			124.7		
Audiology	29.5			29.5		
Manitlaq-Mental Health & DD	156.3			156.3		Does not include Developmental Disabilities.
Norton Sound-Public Health				0.0		
Nursing	518.2			518.2		
EMS	149.2			149.2		
Health Clinic	52.6			52.6	1,600	
Eye Care	43.9			43.9	1,500	
Audiology	46.4			46.4	1,250	
EMS Ambulance Support	2.0			2.0		
Norton Sound-Mental Health	124.7			124.7	235	Does not include Developmental Disabilities or Chronically Mentally Ill.
TCC-Public Health						
Clinic	8.7			8.7		
TCC-Mental Health	168.3			168.3	94	Does not include Chronically Mentally Ill.
YKHC-Public Health				0.0		
Health Care Svcs	334.7			334.7		
EMS	126.4			126.4		
Anchorage Block Grant	628.4			628.4		Based on FY90 subgrantee awards provided by Municipality of Anchorage.

LFD 3/6/90

NOTES TO ACCOMPANY PIONEER HOME HEALTH COST ANALYSIS

1. Figures related to the Governor's FY91 budget request.
2. The items on the spreadsheet represent costs that can be isolated easily from the budget documents. No attempt was made to isolate specialized housekeeping, laundry or equipment that might be more expensive for nursing than for other home residents.
3. Several other items are not enumerated on the spreadsheet which relate to health care costs. These include specialized travel, training, certain health related grants and laboratory expenses. Year to date figures for FY90 indicate these expenses are in the \$50-60,000 range.
4. Calculations from Occupancy Reports provided by the agency for the past 12 months suggest that these expenses are attributable to an average of about 283 residents. This average is composed of full time nursing residents, temporary infirmary patients and residential patients requiring short term nursing care.

DEPARTMENT OF CORRECTIONS
PROJECTED MEDICAL COSTS
FY90

Major Medical Component

	<u>Authorized</u>	<u>Projected</u>	<u>Variance</u>
100	1,110.0	1,257.8	< 147.8>
200	4.0	44.3	< 40.3>
300	3,484.0	4,647.0	<1,163.0>
400	269.0	478.3	< 209.3>
500	0.0	17.7	< 17.7>
TOTAL	<u>4,867.0</u>	<u>6,445.1</u>	<u><1,578.1>*</u>

*Note: Historically, the major medical budget has been underfunded and has received a supplemental legislative appropriation each year to cover essential health care costs.

Medical Personnel Costs Within Institutional Budgets

<u>Component</u>	<u>Number of Positions</u>	<u>Budgeted Costs</u>
Fairbanks Correctional Center	3	\$ 178.0
Yukon-Kuskokwim Correctional Center	2	134.4
Palmer Correctional Center	4	226.1
Mat-Su Pre-Trial	2	86.2
Hiland Mountain Correctional Center	2	106.1
Cook Inlet Pre-Trial	3	135.6
Anchorage Annex Correctional Center	3	158.5
Wildwood Correctional Center	4	184.8
Spring Creek Correctional Center	3	145.0
Lemon Creek Correctional Center	3	132.2
Ketchikan Correctional Center	<u>1</u>	<u>68.5</u>
	TOTAL 30	\$1,555.4

Total Projected Medical Costs

Major Medical	\$6,445.1
Institutional Medical Costs	<u>1,555.4</u>
Total Projected Cost	\$8,000.5

Number of Inmates Served

All inmates booked into state correctional centers receive, at a minimum, a physical and mental health screening. In addition, ongoing health care services, as mandated by the court, are provided to pre and post-convicted inmates.

Projected bookings for FY90	32,000
Daily institutional population capacity	2,516
Average daily medical cost for FY89 (excluding institution medical costs)	\$7.14

FY90 SRS DAT
for HEALTH

Revenue Share

FY90

COMMUNITY	Actual Amount	Formula Amount
ANCHORAGE	1,044,005	\$2,121,000
FAIRBANKS: CITY	410,644	\$834,264
JUNEAU CITY & BORO	396,732	\$806,000
NOME	283,825	\$576,619
KENAI PENINSULA	264,914	\$538,200
KODIAK ISLAND	240,542	\$488,686
SEWARD	210,872	\$428,407
SITKA	172,610	\$350,675
KETCHIKAN	171,294	\$348,000
VALDEZ	164,493	\$334,184
CORDOVA	156,273	\$317,484
PALMER	148,098	\$300,875
BETHEL	142,735	\$289,980
PETERSBURG	139,927	\$284,275
WRANGELL	135,841	\$275,975
NORTH SLOPE	87,753	\$178,278
KENAI: CITY	59,341	\$120,557
SOLDOTNA	51,923	\$105,487
MATANUSKA SUSITNA	49,025	\$99,600
NORTHWEST ARCTIC	38,392	\$77,997
HOMER	25,432	\$51,667
GALENA	21,938	\$44,570
EMMONAK	17,181	\$34,905
CRAIG	15,751	\$32,000
UNALASKA	15,285	\$31,054
ANIAK	10,969	\$22,285
KOTZEBUE	10,969	\$22,285
McGRATH	10,969	\$22,285
SELDOVIA	8,477	\$17,222
HAINES: CITY	8,477	\$17,222
WASILLA	8,171	\$16,200
KLAWOCK	7,876	\$16,000
COLD BAY	7,643	\$15,527
TELLER	5,485	\$11,142
KIANA	5,485	\$11,142
KOYUKUK	5,485	\$11,142
TANANA	5,485	\$11,142
WALES	5,485	\$11,142
NULATO	5,485	\$11,142
GAMBELL	5,485	\$11,142
LOWER KALSKAG	5,485	\$11,142
SAINT MICHAEL	5,485	\$11,142
ANDERSON	5,485	\$11,142
GOLOVIN	5,485	\$11,142
STEBBINS	5,485	\$11,142
GRAYLING	5,485	\$11,142
KOBUK	5,485	\$11,142
SELAWIK	485	\$11,142
UPPER KALSAG	485	\$11,142
HOLY CROSS	5,485	\$11,142
SHUNGNAK	5,485	\$11,142
WHITE MOUNTAIN	5,485	\$11,142

KALTAG	5,485	\$11,142
KIVALINA	5,485	\$11,142
BUCKLAND	5,485	\$11,142
SHAPTOOLIK	5,485	\$11,142
KOYUK	5,485	\$11,142
NOORVIK	5,485	\$11,142
HUGHES	5,485	\$11,142
UNALAKLEET	5,485	\$11,142
AMBLER	5,485	\$11,142
ELIM	5,485	\$11,142
HUSLIA	5,485	\$11,142
BREVIG MISSION	5,485	\$11,142
DEERING	5,485	\$11,142
SHAGELUK	5,485	\$11,142
CHUATHBALUK	5,485	\$11,142
ALAKANUK	5,286	\$10,740
KOTLIK	5,286	\$10,740
KWETHLUK	5,286	\$10,740
MEKORYUK	5,286	\$10,740
GOODNEWS BAY	5,286	\$10,740
SHELDON POINT	5,286	\$10,740
NUNAPITCHUK	5,286	\$10,740
MOUNTAIN VILLAGE	5,286	\$10,740
EEK	5,286	\$10,740
NIGHTMUTE	5,286	\$10,740
CHEVAK	5,286	\$10,740
NAPAKIAK	5,286	\$10,740
CHEFORNAK	5,286	\$10,740
SCAMMON BAY	5,286	\$10,740
PILOT STATION	5,286	\$10,740
QUINHAGAK	5,286	\$10,740
SAINT MARY'S	5,286	\$10,740
RUSSIAN MISSION	5,286	\$10,740
NEWTOK	5,286	\$10,740
NAPASKIAK	5,286	\$10,740
MARSHALL	5,286	\$10,740
TULUKSAK	5,286	\$10,740
AKIAK	5,286	\$10,740
KASIGLUK	5,286	\$10,740
TUNUNAK	5,286	\$10,740
ATMAUTLUAK	5,286	\$10,740
PLATINUM	5,286	\$10,740
TOKSOOK BAY	5,286	\$10,740
DILLINGHAM	5,095	\$10,351
CLARK'S POINT	5,095	\$10,351
BRISTOL BAY BOROUGH	5,095	\$10,351
FORT HEIDEN	5,095	\$10,351
EKWOK	5,095	\$10,351
NEW STUYAHOK	5,095	\$10,351
TOGIAK	5,095	\$10,351
SAINT GEORGE	5,095	\$10,351
KING COVE	5,095	\$10,351
NEWHALEN	5,095	\$10,351
NONDALTON	5,095	\$10,351
ALEKNAGIK	5,095	\$10,351
SAND POINT	5,095	\$10,351

MANOKOTAK	5,095	\$10,351
CHIGNIK	5,095	\$10,351
WHITTIER	4,567	\$9,270
PELICAN	4,237	\$8,611
HOONAH	4,237	\$8,611
YAKUTAT	4,237	\$8,611
SLAGWAY	4,237	\$8,611
LAKE	4,085	\$8,300
ANGDON	4,085	\$8,300
THORNE BAY	3,938	\$8,000
KASAAN	3,938	\$8,000
ALLAKAKET	0	\$0
BETTLES	0	\$0
SHISHMAREF	0	\$0
ANAKTUVUK PASS	0	\$0
BARROW	0	\$0
AKHIOK	0	\$0
FORT YUKON	0	\$0
KAKTOVIK	0	\$0
LARSEN BAY	0	\$0
POINT HOPE	0	\$0
TENAKEE SPRINGS	0	\$0
KUPREANOF	0	\$0
ANVIK	0	\$0
ATKA	0	\$0
PORT LIONS	0	\$0
WAINWRIGHT	0	\$0
OUZINKIE	0	\$0
DELTA JUNCTION	0	\$0
AKUTAN	0	\$0
SAVOONGA	0	\$0
NENANA	0	\$0
SAXMAN	0	\$0
HAINES	0	\$0
NUIOSUT	0	\$0
RUBY	0	\$0
NORTH POLE	0	\$0
PORT ALEXANDER	0	\$0
DIOMEDE	0	\$0
ALEUTIANS EAST BOROU	0	\$0
FAIRBANKS NORTH STAR	0	\$0
NIKOLAI	0	\$0
ATQASUK	0	\$0
OLD HARBOR	0	\$0
EAGLE	0	\$0
KACHEMAK	0	\$0
KODIAK	0	\$0
HOUSTON	0	\$0
HOOPER BAY	0	\$0
SAINT PAUL	0	\$0
HYDABURG	0	\$0

\$4,936,863 \$10,131,308

1989 DISTRIBUTION OF ALASKAN HEALTH CARE PROVIDERS AND FACILITIES

LOCATION	PROVIDERS*																		FACILITIES**				
	AUD	CHI	CSW	DEN	D.HYG	PHYS	PARA	OSTE	POD	OPT	PHAR	O.THR	P.THR	PSYA	PSY	LPN	RN	ANP	TOTAL	ACB	LTCB		
<u>Southeast</u>																							
Angoon																1				1			
Collman Cove																	1				1		
Craig				2		1											1				4		
Gustavus																	3				3		
Haines			1	2	1	3							1			1	7				16		
Juneau	1	7	16	20	17	48	2		1	5	17	4	12	2	8	41	221	4		426	51	92	
Take																1				1			
Ketchikan		3	3	8	5	19				3	14	1	9		4	31	132	6		238	46	76	
Metlakatla				1													1			2			
Petersburg		2	1	2		3					1		2		1	2	29			43	11	16	
Pelican																			1	1			
Sitka	1	1	3	6	3	21	1			1	10	3	6	1	2	19	126	1		205	102	47	
Thorne Bay																1	5			6			
Wrangell		1	1	3	1	2					1					2	18			29	9	18	
SUB-TOTAL	2	15	25	45	27	97	3	0	1	9	43	8	31	3	15	99	544	12		976	219	249	
<u>Southcentral</u>																							
Anchor Pt. & area						2					1					1	8			12			
Anchorage	17	57	90	169	117	445	55	23	6	33	127	48	100	14	57	358	2075	60		3851	806	706	
Cordova		1		1		3					1		1		2	3	19			31	13	12	
Homer		4	2	4	3	10				2	2	1	4		3	14	89	2		140	20	18	
Kenai & area	1	10	1	9	9	20	16	3		3	14	5	8	1	3	33	129	2		267	46	49	
Palmer		3	2	4	5	19	7	1			5	2	12			17	138	7		222	36	59	
Seldovia						1					1						1			3			
Seward		1	1	2	2	3					1	1	1		1	16	31	3		63	32	68	
Talkeetna								2				1				1	6			10			
Valdez		1	1	2		3					2	4				3	25			41	15	84	
Wasilla & area	1	7	1	14	5	7	2	1		3	8	5	8		1	31	114	3		211			
Whittier																1	1			2			
SUB-TOTAL	19	84	98	205	141	513	80	30	6	41	162	67	134	15	67	478	2636	77		4853	968	996	

AUD = Audiologist DEN = Dentist PARA = Paramedic OPT = Optometrist P.THR = Phys. Therapist LPN = Lic. Pract. Nurse ACB = Acute Care Beds
 CHI = Chiropractor D.HYG = Dental Hygienist OSTE = Osteopath PHAR = Pharmacist PSYA = Psychologist Asst. RN = Registered Nurse LTCB = Longer Term Care
 CSW = Clinical Social Worker PHYS = Physician POD = Podiatrist O.THR = Occ. Therapist PSY = Psychologist ANP = Adv. Nurse Pract. Beds

LOCATION	PROVIDERS																		FACILITIES		
	AUD	CHI	CSW	DEN	D.HYG	PHYS	PARA	OSTE	POD	OPT	PHAR	O.THR	P.THR	PSYA	PSY	LPN	RN	ANP	TOTAL	ACB	LTCB
<u>Southwest & Yukon D.</u>																					
Adak																	1		1	15	
Akiak																	1		1		
Bethel	1		4	6	1	5	1	1		1	1		1			4	60	6	92	51	
Cold Bay																	1	1	2		
Dillingham		1		2	1	8	1			1	2			1	1	2	33	1	54	28	
King Cove																	3	2	5		
Kodiak		2	3	8	6	13		3		2	6		6		2	16	71		138	25	23
McGrath																		1	1		
Mekoryuk																	1		1		
Naknek & K.Salmon																2	4	3	9		
Old Harbor																	1	1	2		
Sand Point			1														1		2		
St. Paul Is.							1												1		
Togiak																	1	1	2		
Unalaska & Dutch H.																2	4		6		
SUB-TOTAL	1	3	8	16	8	26	3	4	0	4	9	0	7	1	3	26	180	16	317	119	23
<u>Interior</u>																					
Central																	1		1		
Delta Junction				1			1	1						1		4	7		15		
Eagle																	1		1		
Fairbanks	3	10	18	35	18	116	13	4	1	11	36	8	28		21	98	398	9	827	177	155
Ft. Yukon																	3		3		
Galena																	4		4		
Glennallen & area		2		1							1					3	21		27		
Healy to Cantwell			1				1						1			1	9		13		
Nenana & Anderson																	3		3		
North Pole & Eielson				5	2	4		2	2	1	4	1	2	1	1	24	107	1	157		
Tanana																	5	3	8		
Tok & Dot Lake																	5		5		
SUB-TOTAL	3	12	19	42	20	120	15	7	3	12	41	9	31	1	22	130	564	13	1064	177	155

AUD = Audiologist DEN = Dentist PARA = Paramedic OPT = Optometrist P.THR = Phys. Therapist LPN = Lic. Pract. Nurse ACB = Acute Care Beds
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LOCATION	PROVIDERS																	FACILITIES			
	AUD	CHI	CSW	DEN	D.HYG	PHYS	PARA	OSTE	POD	OPT	PHAR	O.THR	P.THR	PSY A	PSY	LPN	FN	ANP	TOTAL	ACB	LTCB
<u>Northwest & Arctic</u>																					
Atkasuk																	1		1		
Barrow	1		1	1	1	4	2	1		1						1	20	5	38	14	
Gambel																	1	1	2		
Kotzebue			2	1		3				1	1					6	27		41	31	22
Nome	1		5	6	2	5	2	1		1	4		1			4	42	1	75	15	15
Nuiqsut																	2		2		
Unalakleet																1	2		3		
SUB-TOTAL	2	0	8	8	3	12	4	2	0	3	5	0	1	0	0	12	95	7	162	60	37
TOTAL	27	114	158	316	199	768	105	43	10	69	260	84	204	20	107	745	4019	125	7372	1543	1460

* This information is consolidated from the Division of Occupational Licensing lists of current licensees and their residence addresses.

1. It cannot be assumed that all are actively practicing.
2. It does not include all military or Indian Health Service medical personnel.

AUD = Audiologist

CHI = Chiropractor

CSW = Clinical Social Worker

DEN=Dentist

D.HYG = Dental Hygienist

PHYS = Physician

PARA = Paramedic

OSTE = Osteopath

POD = Podiatrist

OPT = Optometrist

PHAR = Pharmacist

O.THR = Occ. Therapist

P.THR = Phys. Therapist

PSY A = Psychologist Asst.

PSY = Psychologist

LPN = Lic. Pract. Nurse

RN = Registered Nurse

ANP = Adv. Nurse Pract.

ACB = Acute Care Beds

LTCB = Longer Term Care

Beds

Alaska State Legislature

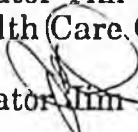


SENATOR JIM DUNCAN

P. O. Box V JUNEAU, ALASKA 99811-3100
(907) 465-4766

COMMITTEES:
FINANCE
VICE CHAIR —
HEALTH EDUCATION
& SOCIAL SERVICES
BUDGET & AUDIT
BANKING &
ECONOMIC
DEVELOPMENT

MEMORANDUM

DATE: May 30, 1990
TO: Senator Tim Kelly, Chair
Health Care Cost Containment Task Force
FROM:  Senator Jim Duncan
RE: Senate Bill 254, Alaska State Group Health Insurance
Authority

I provide the following information on SB254 for the use of the Health Care Cost Containment Task Force. This bill passed the Senate, was slightly modified in the House HESS Committee, but failed to move out of House Finance this session. Attached is a copy of the latest version of the bill and a sectional analysis.

Attachments

Duncan will prefile.

ALASKA STATE GROUP HEALTH INSURANCE AUTHORITY

"An Act relating to group health insurance and to health care provided by the state; and providing for an effective date."

Section 1.

PURPOSE

The purpose of this act is to establish the Alaska State Group Health Insurance Authority. By February 1, 1990 the Authority has the responsibility to create and maintain:

- (a) a rate schedule to be used in Alaska which will reflect the vast geographic differences and availability of services in rural and urban areas;
- (b) statewide utilization standards to control inappropriate or improper utilization practices to reduce the rate of inflation in the cost of health care in Alaska; and
- (c) an efficient provider payment system to reduce the cost to providers who are serving employees of the participants in the authority.

The state, municipalities, and school districts will benefit by using the provider payment system, rate schedule, and utilization standards established by the Authority.

Section 2.

CREATION OF THE AUTHORITY

The authority is established in the Department of Administration. It has a 15 member board of directors appointed by the Governor with the general powers provided to quasi government agencies including the hiring of staff and enter into contracts for professional services. In addition, after February 1, 1992, the Authority may exercise the powers granted to other insurers licensed in the state.

BOARD OF DIRECTORS

The board of directors will be composed of 15 members representing:

- (1) one nonvoting member of the legislative branch;
- (2) one nonvoting member of the judicial branch;
- (3) two members representing the executive branch;
- (4) two members representing labor organizations;
- (5) two members representing school districts;

- (6) two members representing municipalities;
- (7) two members representing the Department of Health and Social Services;
- (8) two members representing health care providers;
- (9) one member representing the University of Alaska.

These appointees serve for a five year term and elect officers from the board membership. They are entitled to per diem and travel expenses but may not otherwise be compensated for their services as a board member. Directors representing districts and municipalities appointed after the initial appointees are to be participants in the group health insurance obtained by the Authority.

POWERS OF THE AUTHORITY

The Authority may:

- (1) after February 1, 1990 exercise the powers granted to insurers under the laws of the state, and shall comply with the requirements applicable to insurers under this title;
- (2) sue or be sued;
- (3) enter into contracts for agreements;
- (4) establish administrative and accounting procedures;
- (5) collect, invest, and disburse funds;
- (6) adopt necessary regulations and procedures for implementation of this chapter.

The authority may not participate in collective bargaining activities.

ANNUAL REPORT, STAFF AND PROFESSIONAL SERVICES

The board shall annually report to the governor and the legislature on its previous fiscal year's activities and every third year include a cost benefit analysis of the health insurance required under this chapter.

The authority shall employ an executive director, who with the approval of the authority may select and employ additional staff as necessary. The authority's employees are in the exempt service. The authority may contract for professional and

technical services it determines necessary to exercise its powers.

PROCUREMENT OF INSURANCE

After February 1, 199⁰²~~8~~ the authority shall purchase a policy or policies of group health insurance covering eligible employees of the state, a municipality, or a district if the employer has elected to participate. The authority may act as a self-insurer if it is determined that self-insurance will provide the desired insurance coverage and benefits at a lower cost per eligible employee.

When purchasing group health insurance the authority shall comply with the provisions of Title 36 and shall make bid specifications available, once every five years, to all insurance carriers licensed in Alaska and qualified to provide the desired benefits.

STATE GROUP HEALTH INSURANCE FUND AND PREMIUMS

The state group health insurance fund is created in the general fund. It consists of appropriations and premiums collected under this title. Money in the fund shall be managed and invested by the board and the board may expend funds from the fund to carry out its operations.

The authority shall collect sufficient premiums to provide the required insurance coverage and to pay the expenses of the authority.

PARTICIPATION AND WAIVER

The authority may also grant a waiver of participation to the state, a municipality or a school district who has elected to participate. The board may approve or disapprove a waiver when the participant can document the ability to match the minimum benefit and financial standards established by the board for the desired group health coverage. A waiver may be granted when a participant certifies that its' employees will not have health care coverage from the authority or other carrier.

Participants may separately provide for health insurance in addition to that provided by the Authority.

DEFINITIONS

(1) authority, means the Alaska State Group Health Insurance Authority;

- (2) board, means the board of directors of the Alaska Group Health Insurance Authority;
- (3) district, means a school district or REAA;
- (4) eligible employee, means an employee qualified for group health insurance benefits as determined by the participant;
- (5) eligible state program, is a program with which a state agency provides health care or funds to purchase health care for persons not employed by the state;
- (6) employer, means the state, a municipality, a district, a collective bargaining unit, or the board of a public corporation of the state created within a principal executive department;
- (7) fund, means the state group health insurance fund;
- (8) group health insurance, means coverage that may include life insurance, accidental death and dismemberment, workers' compensation, medical care and treatment including Medicare and Medicaid, dental care, eye care, and other group health coverage as determined by the authority;
- (9) municipality, includes a public corporation established by a municipality;
- (10) participant, means the state, a municipality, or a district;
- (11) payment system, means a system or method to streamline and effect cost efficient payments to health care providers.
- (12) rate schedule, means a schedule of allowable payments for health care related services rendered based on geographic regions actual provider cost and availability of services.
- (13) state, means the executive, legislative, and judicial branches of state government, or an organizational unit of a branch, and includes the University of Alaska, and a public corporation of the state created within a principal executive department.
- (14) utilization review, means a system to monitor, track and verify patterns of treatment by health care providers to assure that the most efficient and cost effective care is delivered within accepted standards with out reducing quality of care.

Section 3.

Places employees of the authority in the exempt service.

Section 4.

Requires board members of the authority to comply with the conflict of interest statutes.

Section 5.

Provides that terms of the board members will be staggered.

Section 6.

The Authority is required to make a progress report to the Legislature by March 1, 1991. The report covers the Authorities efforts in establishing the health care provider payment system, rate schedule, and utilization standards.

Section 7.

Provides for an immediate effective date.

Original sponsor(s): SEN. DUNCAN, Kerttula

1 IN THE SENATE BY THE HESS COMMITTEE
2 HOUSE CS FOR CS FOR SENATE BILL NO. 254 (HESS)
3 IN THE LEGISLATURE OF THE STATE OF ALASKA
4 SIXTEENTH LEGISLATURE - SECOND SESSION

5 A BILL

6 For an Act entitled: "An Act relating to group health insurance and to
7 health care provided by the state; and providing for
8 an effective date."

9 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

10 * Section 1. PURPOSE. The purpose of this Act is to

11 (1) by February 1, 1992, create a statewide health care provider
12 payment system, rate schedules, and utilization standards;

13 (2) after February 1, 1992, provide comprehensive group health
14 insurance for the state, municipalities, school districts, and all eligible
15 employees of the state, a municipality, or a school district who elect to
16 participate in the group insurance offered by the Alaska State Group Health
17 Insurance Authority;

18 (3) expand the pool of subscribers and maximize the opportuni-
19 ties for cost containment when purchasing group health insurance;

20 (4) maintain an efficient provider payment system to reduce the
21 cost to providers who are serving employees of participants;

22 (5) maintain statewide utilization standards to control inappro-
23 priate or improper utilization practices and to reduce the rate of infla-
24 tion in the cost of health care in the state;

25 (6) create the most comprehensive, cost-effective, and efficient
26 method of providing a variety of types of health care insurance necessary
27 to meet the coverage requirements of a participant resulting from negoti-
28 ated employee contracts;

29 (7) realize the potential savings that will result if

1 approximately 135,000 active and retired state, municipal, and school
2 district employees and their dependents participate in the group health
3 insurance program offered by the authority; and

4 (8) determine the need for mandatory participation in the group
5 health insurance offered by the authority.

6 * Sec. 2. AS 21 is amended by adding a new chapter to read:

7 CHAPTER 77. STATE INSURANCE.

8 Sec. 21.77.010. AUTHORITY CREATED; REQUIRED PAYMENT SYSTEM, RATE
9 SCHEDULE, AND UTILIZATION STANDARDS. (a) There is established within
10 the Department of Administration a nonprofit incorporated legal entity
11 known as the Alaska State Group Health Insurance Authority.

12 (b) The authority shall, by February 1, 1992, establish and
13 maintain a health care provider payment system, rate schedules, and
14 utilization standards. The state, a municipality, or a school dis-
15 trict shall use the health care provider payment system, rate sched-
16 ules, and utilization standards established by the authority for
17 eligible employees of the state, municipality, or a school district.

18 (c) The authority shall, beginning February 1, 1992, provide
19 group health insurance to eligible employees of the state, a munici-
20 pality, or a school district if the employer has elected to partici-
21 pate in the group health insurance obtained by the authority and may
22 provide group health insurance to employees of other groups that elect
23 to participate in the group health insurance obtained by the author-
24 ity.

25 (d) Upon application by an eligible state program, the authority
26 may, beginning February 1, 1992, allow the eligible state program to
27 participate in the group health insurance obtained by the authority.

28 Sec. 21.77.015. REQUIRED COOPERATION BY STATE AGENCIES. An
29 agency of the state that provides health care or that provides funds

1 to purchase health care shall, to the maximum extent possible, cooper-
2 ate in the development of the use of the health care provider payment
3 system, rate schedules, and utilization standards established by the
4 authority, including sharing relevant information.

5 Sec. 21.77.020. BOARD OF DIRECTORS; ORGANIZATION. (a) The
6 authority shall be managed by a board of directors composed of 15
7 members appointed by the governor as follows:

8 (1) one nonvoting member representing the legislative
9 branch;

10 (2) one nonvoting member representing the judicial branch;

11 (3) two members representing the executive branch;

12 (4) two members representing labor organizations;

13 (5) two members representing school districts;

14 (6) two members representing municipalities;

15 (7) two members representing the Department of Health and
16 Social Services;

17 (8) two members representing health care providers;

18 (9) one member representing the University of Alaska.

19 (b) A member of the board serves for a term of five years. The
20 board shall elect from its membership a president, vice-president, and
21 secretary. Members of the board serve without compensation but are
22 entitled to receive per diem and travel expenses authorized for boards
23 and commissions under AS 39.20.180. Members of the board are subject
24 to AS 39.50.

25 (c) Members appointed under (a)(5) of this section shall be
26 employees of a school district that has elected to participate in the
27 group health insurance obtained by the authority. Members appointed
28 under (a)(6) of this section shall be employees of a municipality that
29 has elected to participate in the group health insurance obtained by

1 the authority.

2 Sec. 21.77.030. GENERAL POWERS. (a) The authority may

3 (1) beginning February 1, 1992, exercise the powers granted
4 to insurers under the laws of the state; if the authority acts as an
5 insurer, the authority shall comply with the requirements applicable
6 to insurers under this title;

7 (2) sue or be sued;

8 (3) enter into contracts or agreements;

9 (4) establish administrative or accounting procedures;

10 (5) collect, invest, and disburse funds;

11 (6) adopt necessary regulations and procedures for imple-
12 mentation of this chapter.

13 (b) In exercising its powers under this chapter, the authority
14 may not participate directly or indirectly in a collective bargaining
15 agreement.

16 Sec. 21.77.040. DUTIES OF BOARD; ANNUAL REPORT. The board
17 shall, in obtaining group health insurance required under this chap-
18 ter, provide comprehensive coverage at the lowest possible cost per
19 eligible employee. The board shall provide to the governor and to the
20 legislature an annual report covering the previous fiscal year's
21 activities of the authority. Every third fiscal year the authority
22 shall include in the annual report a cost and benefit analysis of the
23 health insurance required under this chapter.

24 Sec. 21.77.050. STAFF AND PROFESSIONAL SERVICES CONTRACTS. The
25 authority shall employ an executive director who serves at the plea-
26 sure of the authority as its chief administrative officer. The execu-
27 tive director may, with the approval of the authority, select and
28 employ additional staff as necessary. Employees of the authority are
29 in the exempt service under AS 39.25.110. In addition to its staff of

1 regular employees, the authority may contract for the services of
2 consultants and professional, technical, and financial advisors the
3 authority considers necessary for the purpose of developing informa-
4 tion, conducting hearings, studies, investigations, or other proceed-
5 ings, or otherwise exercising its powers.

6 Sec. 21.77.060. PROCUREMENT OF INSURANCE. (a) The authority
7 shall, after February 1, 1992, obtain a policy or policies of group
8 health insurance covering eligible employees of the state, a munic-
9 ipality, or a district, if the employer has elected to participate,
10 from an insurer authorized to transact business in the state under
11 AS 21.09, or act as a self-insurer if the authority determines that
12 self-insurance can provide the desired insurance coverage and benefits
13 at a lower cost per eligible employee.

14 (b) Except when acting as a self-insurer, the authority shall
15 obtain group health insurance in compliance with the provisions of
16 AS 36.30 and shall make available bid specifications for desired group
17 health insurance benefits to all insurance carriers licensed in the
18 state and qualified to provide the desired benefits. The specifica-
19 tions shall be made available at least once every five years.

20 Sec. 21.77.070. STATE GROUP HEALTH INSURANCE FUND. The state
21 group health insurance fund is created in the general fund. The fund
22 consists of money appropriated by the legislature, and premiums col-
23 lected under AS 21.77.080. The fund shall be managed and invested by
24 the board. The board may expend money from the fund to carry out the
25 provisions of this chapter.

26 Sec. 21.77.080. INSURANCE PREMIUMS. (a) The authority shall
27 provide that sufficient premiums are collected to provide the re-
28 quired insurance coverage and to pay the expenses of the authority.
29 All premiums shall be deposited in the fund.

1 (b) Reserves remaining at the termination of an insurance con-
2 tract shall be invested by the authority in the same manner as retire-
3 ment funds are invested under AS 14.25.180.

4 Sec. 21.77.090. PARTICIPATION; WAIVER. (a) The state, a munic-
5 ipality, or a district may participate in the group insurance coverage
6 provided by the authority. If the state, municipality, or district
7 elects to participate, the state, municipality, or district shall
8 continue to participate unless a waiver is granted by the board.

9 (b) In determining whether a waiver should be granted, the board
10 shall establish minimum benefit and financial standards for the de-
11 sired group health insurance coverage. The minimum benefit and finan-
12 cial standards and the proposed time schedule for responsive offers
13 shall be sent to all participants at the time the request for proposal
14 for the desired group health insurance coverage is issued. Except as
15 provided in (d) of this section, a participant seeking a waiver of
16 coverage shall match the minimum benefit and financial standards set
17 out in the request for proposal for the desired group health insurance
18 coverage. Participants shall submit documentation of their insurance
19 coverage matching the board's minimum benefit and financial require-
20 ments before the deadline established by the board. The board may
21 approve or disapprove a waiver of participation based on the documen-
22 tation submitted by the participant regarding the benefit and finan-
23 cial standards established by the board.

24 (c) A participant may separately provide for health insurance
25 coverage additional to that offered by the authority, and may provide
26 for marketing and servicing to be done by licensed insurance agents.

27 (d) The board shall grant a waiver to a participant who elects
28 not to provide group health insurance to employees. A waiver granted
29 under this subsection takes effect at the expiration of the existing

1 health insurance coverage.

2 Sec. 21.77.100. DEFINITIONS. In this chapter

3 (1) "authority" means the Alaska State Group Health Insur-
4 ance Authority;

5 (2) "board" means the board of directors of the Alaska
6 State Group Health Insurance Authority;

7 (3) "district" has the meaning given in AS 14.17.250;

8 (4) "eligible employee" means an employee of a participant
9 who qualifies for group health insurance benefits as determined by the
10 participant;

11 (5) "eligible state program" means a program in which an
12 agency of the state provides health care or provides funds to purchase
13 health care for persons who are not employees of the state;

14 (6) "employer" means the state, a municipality, a district,
15 a collective bargaining unit, or the board of a public corporation of
16 the state created within a principal executive department;

17 (7) "fund" means the state group health insurance fund;

18 (8) "group health insurance" means coverage that may in-
19 clude life insurance, accidental death and dismemberment, medical care
20 and treatment, dental care, eye care, and other group health coverage
21 as determined by the authority;

22 (9) "municipality" includes a public corporation estab-
23 lished by a municipality;

24 (10) "participant" means the state, a municipality, or a
25 district;

26 (11) "payment system" means a system or method that stream-
27 lines or results in cost efficient payments to health care providers;

28 (12) "rate schedules" means schedules of allowable payments
29 for health care related services based on geographic regions, actual

1 provider costs, and availability of services;

2 (13) "state" means the executive, legislative, and judicial
3 branches of state government, or an organizational unit of a branch,
4 and includes the University of Alaska and a public corporation of the
5 state created within a principal executive department;

6 (14) "utilization standards" means a system to monitor,
7 track, and verify patterns of treatment by health care providers that
8 assures that cost efficient and cost effective care is provided within
9 accepted medical standards without reducing the quality of care.

10 * Sec. 3. AS 39.25.110 is amended by adding a new paragraph to read:

11 (30) employees of the Alaska State Group Health Insurance
12 Authority.

13 * Sec. 4. AS 39.50.200(b) is amended by adding a new paragraph to read:

14 (50) Alaska State Group Health Insurance Authority (AS 21.-
15 77).

16 * Sec. 5. STAGGERED INITIAL TERMS; INITIAL APPOINTMENTS. Notwithstand-
17 ing AS 21.77.020(b), enacted in sec. 2 of this Act, the terms of the ini-
18 tial members of the board of directors of the Alaska State Group Health
19 Insurance Authority who are appointed under AS 21.77.020(a), enacted in
20 sec. 2 of this Act, shall be staggered by the governor. Three members
21 shall serve for one year, four members for two years, four members for
22 three years, and four members for four years. AS 21.77.020(c), enacted in
23 sec. 2 of this Act, does not apply to members appointed to the initial
24 board of directors of the Alaska State Group Health Insurance Authority.

25 * Sec. 6. REPORT. The Alaska State Group Health Insurance Authority
26 shall report to the Alaska State Legislature by March 1, 1991, on the
27 progress made by the authority in establishing a health care provider
28 payment system, rate schedules, and utilization standards.

29 * Sec. 7. This Act takes effect immediately under AS 01.10.070(c).

DONALD W. SEILER

3456 Kant Court Juneau, Alaska 99801 (907) 789-2495

PROFESSIONAL EXPERIENCE

1989-present JUNEAU RACQUET CLUB, JUNEAU, ALASKA
General Manager

Manage all aspects of programming and operations at a full service health/fitness facility. i am accountable for all financial management including budget, accounts receivable, accounts payable, and cash management. I write and update the business and marketing plans and am responsible for their implementation.

ACCOMPLISHMENTS Developed, marketed, and supervised implementation of a health promotion program for 700 municipal employees. Developed a marketing program that resulted in the highest new member enrollment in 12 years.

1987-1989 ST. JOSEPH'S HOSPITAL, TAMPA,
FLORIDA
Director of Health Promotion

Managed all health promotion activities at a 750 bed metropolitan hospital. Responsibilities include management of a 14,000 square foot fitness center. Was accountable for all aspects of fitness center operation, including marketing, a \$950,000 budget and a staff of 22 FTE's. Additional health promotion responsibilities included preparation of proposals and program development for corporate clients. I served as behaviorist in weight management program for moderate and morbidly obese patients and taught nutrition, smoking cessation, stress management, and other disease prevention programs.

ACCOMPLISHMENTS Supervised development of a 12 week cholesterol control program.
Developed smoking cessation program with 56% quit rate on 1 year follow-up..
Supervised health promotion program for 2,700 hospital employees.
Conducted all start-up activities of fitness center from opening to one year membership of 1325 members.
Fiscal year 1989-90 ended with a 28% return on sales.

1986-1987

ST. JOSEPH'S HOSPITAL, TAMPA, FL
Health and Sports Institute Director

Total responsibility for all aspects of health promotion programming at a major destination resort. Developed customized educational programs for visiting corporations including stress management, health risk appraisal, and lifestyle management for health promotion.

ACCOMPLISHMENTS

Developed weight training program for preadolescent gymnasts.
Certified by Johnson and Johnson Health Management Inc. to deliver stress management, weight control, nutrition, and smoking cessation programs.
Served as nutrition consultant to the Tampa Bay Buccaneers professional football team.

1984-1986

UNIVERSITY OF HOUSTON AT CLEAR LAKE,
HOUSTON, TEXAS
Health Promotion Coordinator

Responsibility for development and delivery of health promotion programs for corporate clients. Conducted testing in the human performance lab using treadmill, hydrostatic weighing, skinfold calipers, and spirometry. Prepared individual exercise prescriptions based on test results. Using Cybex equipment, conducted strength assessments for astronaut selection. Implemented special events including weight loss competitions, walkfests, and blood pressure survey programs. Instructed Employee Fitness Exercise Classes for ages 16-70. Developed and implemented instructor training workshop for new instructors. Conducted physical abilities testing for prospective employees on job related skills and gross motor skills.

ACCOMPLISHMENTS

Developed Fitness Instructor Workshop with total enrollment of 75 participants.
Edited and wrote monthly newsletter which included current information on health related topics.
Developed and conducted blood pressure screening program for 4000 school district employees.

Other significant work experiences:

1979-1984 Commercial Helicopter Pilot
Houston, TX and Anchorage, AK

Flew in support of fire suppression, biological surveys,
and offshore oil and gas production.

1978-1979 Fitness Facility Manager
Nautilus of Texas, Houston, TX

1976-1978 Park Caretaker
Champion Papers, Pasadena, TX

1970-1976 Maintenance Manager/Combat Helicopter
Pilot
U.S. Army

EDUCATION

UNIVERSITY OF HOUSTON at CLEAR LAKE: MA, May 1986
Major: Human Performance
Minor: Psychology

UNIVERSITY OF HOUSTON at CLEAR LAKE: BS, May 1985
Major: Health, Leisure and Sports
Minor: Business Administration

PROFESSIONAL ASSOCIATIONS

American College of Sports Medicine
National Strength and Conditioning Association
Association for Fitness in Business - Book Reviewer

PROFESSIONAL CERTIFICATIONS

American College of Sports Medicine - Health and Fitness
Instructor
American Red Cross - CPR, Basic First Aid, Advanced
Lifesaving

PERSONAL

Happily married, wife: Kim
Four children: Tara 12, Andy 4, Ryan 2, Merideth 4
months
Excellent physical condition

An Overview Of:

Corporate
Health Promotion
Programs

Presented To:

The State of Alaska
Health Care Cost Containment
Task Force

Presented By:

Positive Health Options
a division of the
Juniata Racquet Club

Rising Health Care Costs - The Problem

Health care costs are growing at a rate much higher than the consumer price index. Total health care costs in the U.S. were:

- *1973 - \$200 billion
- *1983 - \$360 billion
- *1993 - expected to be \$1 trillion!

At the same time, employer contributions have grown from 6% to an anticipated 40% of total expenditures.

*Chrysler estimates that approximately \$220 of the cost of each automobile is due to employee health care costs

*General Motors spent more on employee health care costs than on steel for its automobiles

There are many causes for increased health care costs:

- *Increased use of expensive technology
- *Expensive drug therapies
- *Rising cost of mental health services
- *Larger and more frequent claims for catastrophic illnesses
- *Reduced Medicare payments

The National Center for Health Statistics reported that approximately 70% of all health care expenditures are a result of lifestyle choices:

- *Of the 10 leading causes of death, heart disease and cancer account for 6% of all those fatalities
- *53% of all cardiovascular deaths and 60% of all cancer deaths are due to the effects of lifestyle
- *The National Chamber of Commerce estimates that businesses lose 52 million work days due to heart disease

Cost Containment Efforts

American businesses are trying a variety of cost containment techniques, including:

- *Expense Management

- *Prospective Review
- *Concurrent Review
- *Retrospective Review

- *Benefit Reduction

- *Alternative Delivery Systems

- *Health Maintenance Organizations
- *Preferred Provider relationships
- *Ambulatory Surgery
- *Utilization Education

- *Utilization Reduction

- *Health Promotion
- *Employee Assistance

Health Promotion Programs

Comprehensive health promotion programs have achieved impressive results:

- *Johnson & Johnson - \$378 per employee cost savings
- *NASA - 52% improvement in job performance
- *Kennecott Copper - 58% reduction in absenteeism
- *General Motors - 60% decrease in sickness and accident payments within 1 year of implementing an employee assistance program

Components of a comprehensive health promotion program are:

- *Awareness - Media campaigns, newsletters
- *Assessment - Health Risk Appraisals, blood pressure
- *Lifestyle Change - Smoking cessation programs, weight loss programs
- *Environmental Support - Smoking policies, flex-time, exercise facilities

The Products

There are many levels of corporate health promotion programming. The following descriptions detail some of the options that are available:

Level 1 - Awareness and Education

Quarterly campaigns to increase awareness of selected area of health concern. Each campaign will include:

1. On-site posters to create interest in program and encourage attendance.
2. Reproducible hand-outs to increase awareness and provide education.
3. 1/2 hour to 1 1/2 hour lectures about the selected topics.

The number of sessions depends upon the number of shifts and employees.

Level 2 - Appraisal, Awareness, and Education

This quarterly campaign is similar to the above program, but includes the addition of some form of health screening (such as cholesterol screening, hypertension screening, etc.). Costs are determined by test selection, number of employees, and number of shifts.

Level 3 - Off-site Program Management

Following a complete analysis of needs, including management assessment and employee assessment, a system will be designed to provide on-going health promotion activities. The specific needs of the corporation will be addressed in a mutually agreed upon program. A Health Promotion Coordinator will be on-site 2-3 days per week, depending upon current needs. The Positive Health Options Health Promotion Manager will maintain contact with the client's representative to insure quality of programming and to identify new program needs.

Level 4 - On-site Program Management

Following a complete analysis of needs, including management assessment and employee assessment, a system will be designed to provide on-going health promotion activities. The specific needs of the corporation will be addressed in a mutually agreed upon program. A Health Promotion Coordinator will be based on-site. The Health Promotion Manager will maintain contact with the client's representative to insure quality of programming and to identify new program needs.

In addition to the above health promotion systems, Positive Health Options can provide the following lifestyle intervention programs:

- *Smoking Cessation
- *Stress Management
- *Weight Management
- *Exercise

The experts at Positive Health Options can help an organization design programs and facilities, including site selection, personnel selection, and equipment selection.

The Organization

In addition to purchasing a product and services, you are also buying an organization. The Juneau Racquet Club opened in 1978 as an indoor racquet and exercise facility. Always on the leading edge of fitness and recreation, the club was among the first in Alaska to offer group aerobic classes (1980), fitness testing (1982), and wellness programs (1984).

Positive Health Options began as a division of the Juneau Racquet Club in 1989. At that time Positive Health Options began the management of a comprehensive health promotion program for the City and Borough of Juneau. This program is the first comprehensive municipal wellness program and serves as a model for those to come.

The staff of Positive Health Options is highly qualified and experienced in management of Corporate Health Promotion Programs as well as delivery of behavioral intervention programs. Their expertise includes exercise physiology, behavioral science, business management.

Advantages of choosing Positive Health Options are:

- *Responsive to employee and management needs
- *Confidentiality for participants is assured, improving response
- *Integration of all aspects of programming
- *Single source for all health promotion needs
- *Experienced, qualified staff
- *Expertise available to the private sector
- *Full time staffing

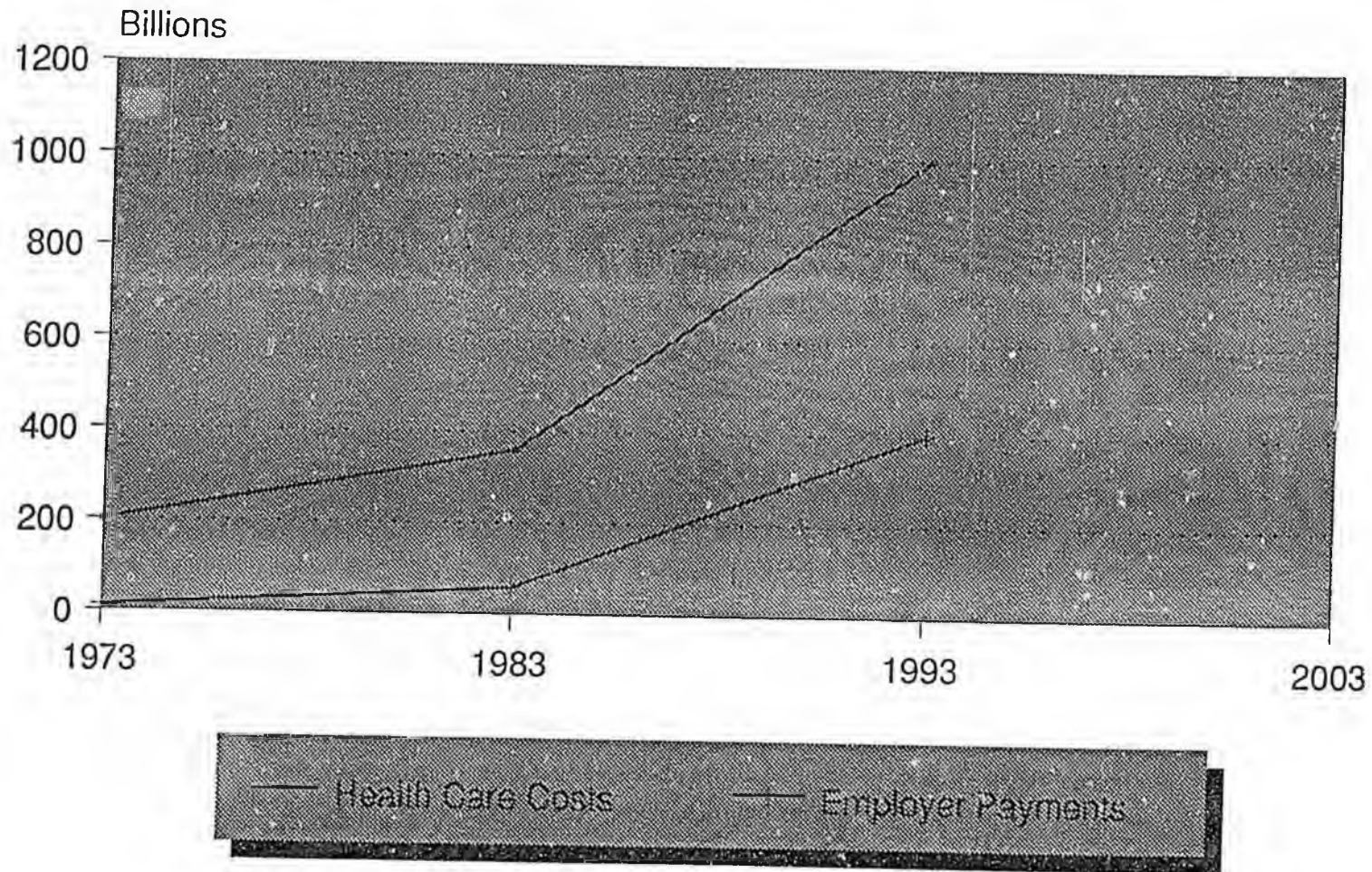
Worksite Health Promotion: An Alaskan Perspective

Positive Health Options



a division of the
Juneau Racquet Club

American Health Care Costs and Employer Contributions



Solutions To Rising Costs

- Expense Management
 - Prospective Review
 - Concurrent Review
 - Retrospective Review
- Reduced Benefits
- Alternative Delivery Systems
- Co-Payments
- Utilization Reduction
 - Health Promotion
 - Employee Assistance

Results of Health Promotion Programs

- Johnson & Johnson - \$378 per employee cost savings
- New York Telephone - \$2,700,000 cost savings
- NASA - 52% improvement in job performance
- Kennecott Copper - 58% reduction in absenteeism and 55% reduction in medical costs
- General Motors - 60% decrease in sickness and accident payments in one year

HEALTH PROMOTION PROGRAM COMPONENTS

Examples

Awareness

Media Campaigns
Newsletters
Health Screenings

Assessment
(Monitoring & Follow-up)

Health Screenings
with monitoring and follow-up
Employee Assistance Program

Lifestyle Change
(Education & Skill Building)

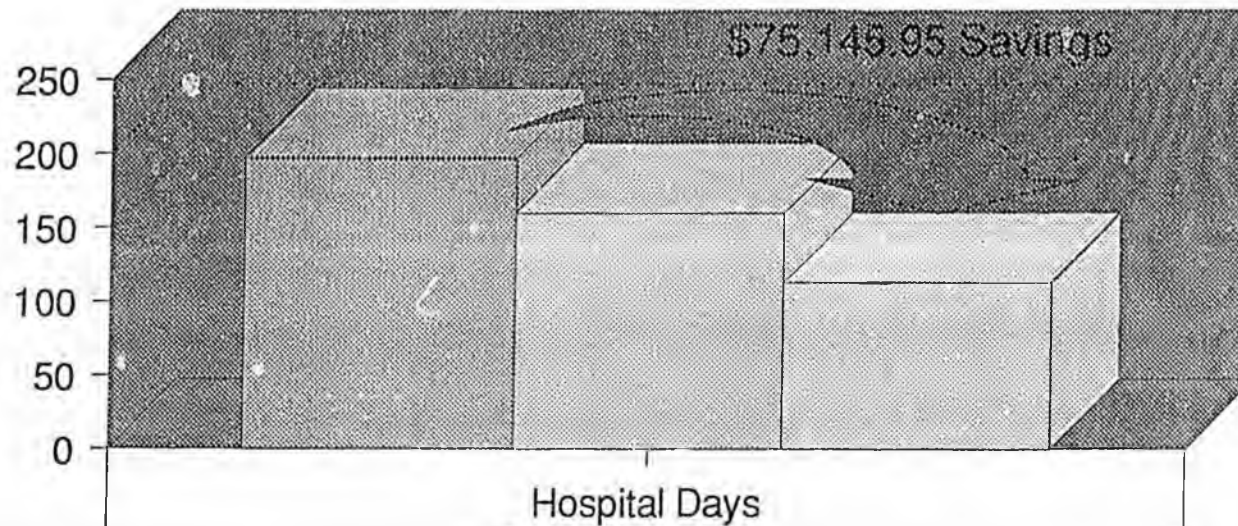
Smoking Cessation Programs
Weight Loss Programs
Stress Management Programs

Environmental
Support

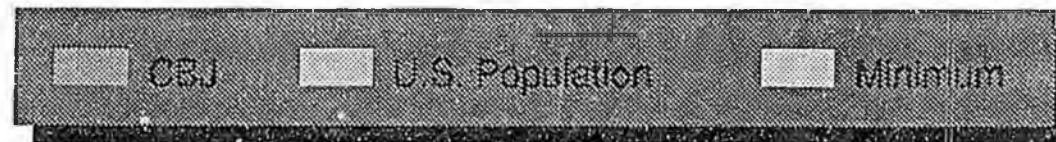
Smoking Policies
Cafeteria Programs
Vending Machine Programs
Exercise Breaks
Flex-Time

Health Yourself

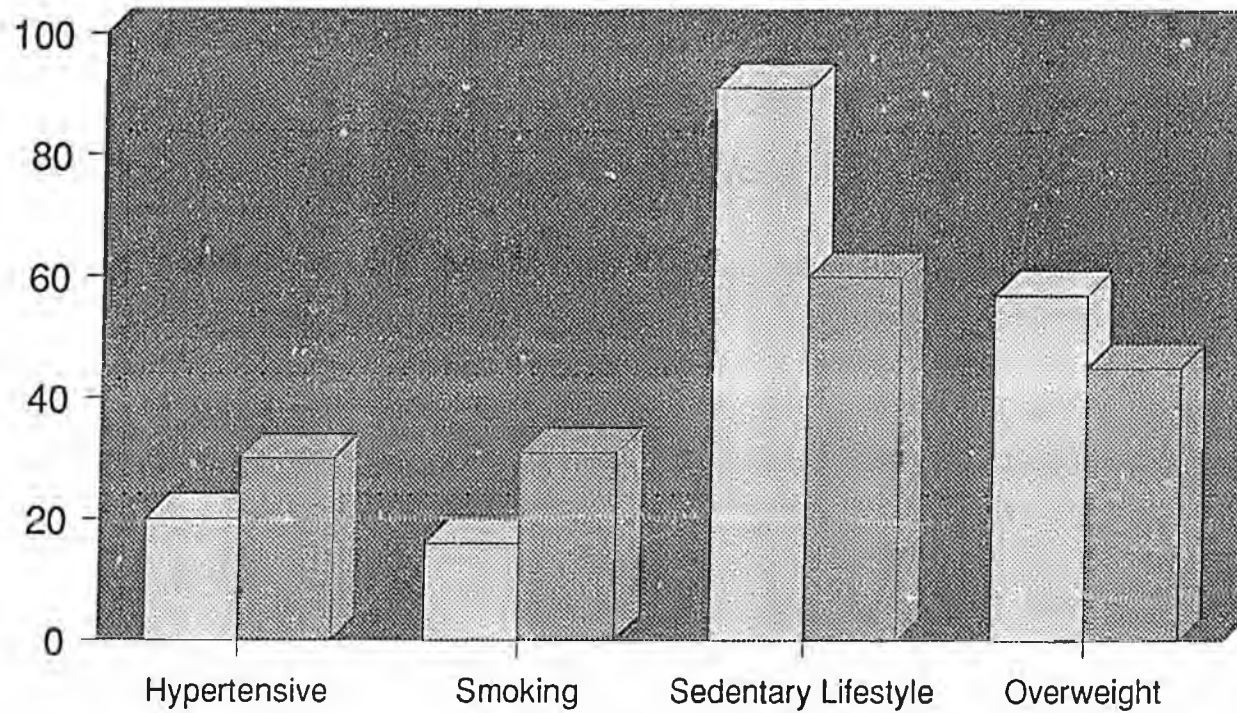
Reduction in Hospital Days




	Hospital Days
CBJ	197.17
U.S. Population	160.15
Minimum	112.92



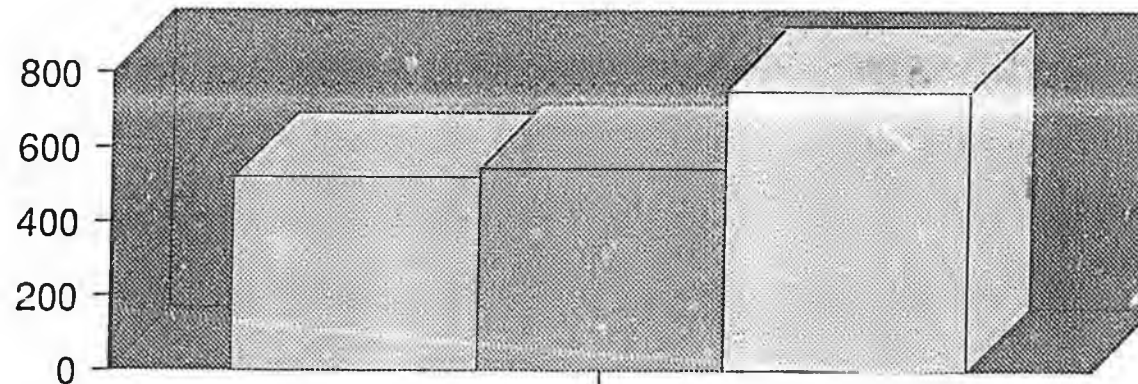
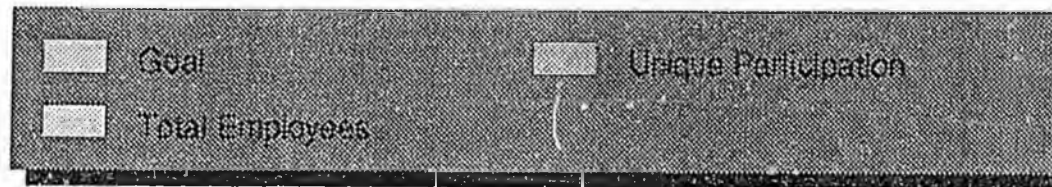
Health Yourself



CBJ	20	16	91	57
U.S. Population	30	31	60	45

Legend:  CBJ  U.S. Population

Health Yourself Unique Participation



Goal	521	70%	of Total Employees
Unique Participation	545	72%	of Total Employees
Total Employees	753		

Health Yourself

Positive Health Options

Advantages

- Responsive to employee and management needs
- Confidentiality for participants is assured, improving response
- Integration of all aspects of programming
- Single source for all health promotion needs
- Experienced, qualified staff
 - Expertise available in private sector
 - Full time staffing

COORDINATION OF BENEFITS AND "DOUBLE COVERAGE"

In today's society, families in which both adults are employed are common. If the employers of both adults provide their workforce with medical/dental insurance, it is possible for one or both to have "double coverage."

When a covered employee or dependent has insurance from two insurance carriers, "coordination of benefits" provisions set the rules for the payment of claims. Under these provisions, one plan is "primary" and one plan is "secondary." The primary plan pays regular benefits in full. The secondary plan pays a reduced amount which, when added to the benefits paid by the primary plan, will equal no more than 100% of the medical/dental expense.

A plan that does not coordinate benefits is always the primary plan. Subject to variances mandated by some states, if both plans coordinate, the primary plan is determined as follows:

...The plan which covers the patient as an employee, rather than as a dependent, is primary.

...If a child is a covered dependent under both plans, a plan covering the parent whose birthday falls earlier in the year determines its benefits before a plan covering the parent whose birthday falls later in the year. (In some states the father's plan is primary) However, if the parents are legally separated or divorced, benefits will be payable under the plan of the parent with custody of the child, except as follows: if a court decree has established financial responsibility for the child's covered expenses, benefits will first be payable under the plan of the parent who has that responsibility, and that parent's plan is primary.

...A plan covering a person as an employee (or dependent of such employee) who is not laid-off or retired determines its benefits before a plan covering a person as a laid-off or retired employee (or dependent of such employee).

Assuming a situation in which the plans of both adults pay benefits on an 80%/20% basis after the deductible and in which both deductibles have been met, one plan will pay an 80% benefit and one will pay a 20% benefit. Both insurance carriers receive a 100% premium.

Employers in the private sector have found that requiring an employee to contribute even a token amount of his or her own premium and the dependents' premium motivates employees to responsibly evaluate the need for "double coverage."

There is a potential danger for an employee who elects not to enroll himself/herself or dependents in an employer's plan when the opportunity to do so is first available. If coverage under one plan terminates because of lay-off, termination of employment or retirement, the persons now without coverage will be "late entrants" if they apply for coverage under the (remaining) other plan.

Late entrants must provide evidence of insurability when applying for coverage. This must usually be provided at no expense to the insurance carrier and it will be subjected to close scrutiny. Late entrants may be declined, approved with exclusions for pre-existing conditions or approved with no restrictions. In

some plans, late entrants may be subject to waiting periods before some coverages take effect. Some insurance carriers liberalize late entrant penalties if the applicant can show that a change in the availability of "other coverage" has taken place and that application is being made within 30 days of this event.

COBRA (Consolidated Omnibus Budget Reconciliation Act) regulations ameliorate the loss of coverage from a group plan maintained by an employer with 20 or more employees. Employees terminating from a firm subject to this law may continue coverage for themselves and their dependents for up to 18 months at their own expense. COBRA offers a short term solution to terminating employees. Those returning to the workforce with a firm that provides group insurance without an "evidence of insurability" requirement and those doing this early enough to satisfy the new firm's probationary period before COBRA's 18 months have expired will not have a problem. Uninsurable persons who lose coverage for any reason may regret an earlier decision not to elect "double coverage."

It does not appear to be unethical to motivate an employee (by asking him or her to pay an affordable part of the premium) to responsibly evaluate the need for double coverage for himself/herself and/or his or her dependents.

PREMIUM REDUCTION

Health Insurance plan changes which should result in reductions in premiums include the following:

- ...Increase individual deductible
- ...Increase family deductible maximum
- ...Increase individual coinsurance maximum*
- ...Increase family coinsurance maximum*
- ...Delete first dollar accident coverage
- ...Delete first dollar hospital coverage
- ...Delete routine maternity care coverage**
- ...Require preauthorization for hospital confinement
- ...Add inpatient hospital deductible
- ...Enter into a preferred provider arrangement
- ...Require a second surgical opinion
- ...Delete coverage for specified charges:
 - _Dental
 - _Vision
 - _Rx Drugs
 - _Mental Health
 - _Alcoholism
 - _Drug abuse
 - _Chiropractic

* Coinsurance is that part of a covered charge (often 20%) above the deductible which is payable by the insured person. Most health insurance plans limit an insured person's coinsurance liability to a specific calendar year maximum. Some plans feature a family maximum.

** Federal law requires employers with 15 or more employees who have a group insurance plan to provide coverage for pregnancy on the same basis as coverage for any other medical condition. The law does not require that the employer provide this benefit within the group insurance program.

NOTE: Adoption of some of the changes listed above may violate laws of a given jurisdiction. Employers are advised to seek legal counsel when making reductions in coverage.

Health costs not evident to consumer

By DAVID STRATTON

As a broker in the health insurance field I am constantly asked to explain why this coverage is so expensive. All too often the coverage is not available at any price. What has happened to bring us to this crossroads today?

Medical services are more in demand today than ever before. Many services in America experience a decline in demand as their price increases, however, this does not seem to be the case with medical services. As a matter of fact, the demand doesn't seem to be slowed at all by the spiraling price increases. Just the opposite appears to be true. Why is this?

Who pays for most the medical services provided today? If you need food and shelter you will purchase groceries at the store and look for a home to rent or purchase. You actually look for what you can afford because you will be paying according

to what is charged. This creates an informed and cautious shopper.

But who pays for most of the medical services the consumer uses? A third party payor is most often present in the payment for medical services. This allows the consumer to pay little or nothing of the total cost of health care.

Many times the billing for these services is sent directly to the third party and the consumer has no idea of the accuracy or the quantity of the billing. This puts many consumers totally out of touch with the cost of the medical services which they are using.

There can be little hope of curtailing the increasing spiral of costs until the end user of these products becomes involved in the cost portion of the program. Currently the premium for the insurance is mostly paid by the employer and the employee pays a small portion of the

medical bills.

Possible solutions to this problem of cost include government sponsored plans with no direct cost to the consumer.

Large employers have found that a distinct relationship exists between the use of a plan and out-of-pocket expense to the employee. The higher the out-of-pocket costs, the lower the use of the plan benefits.

In addition these employees and their dependents are not going without needed medical care. In fact they are using the plan benefits when needed and changing their life styles as well. Many employees had quit smoking and limited their drinking habits. Exercise had also become a

part of their lives on a regular basis.

All in all, the employees discovered what the actual costs of medical were and took the option of improving their health and reducing their dependence on plan benefits.

These results may well point to one of the main culprits of the price spiral in employee health benefits. Possibly we can all see that culprit by taking a long look deeply into the bathroom mirror.

The author is a member of the Alaska Association of Independent Agents and Brokers, president of the Alaska Association of Life Underwriters, and president of the Alaska Chapter of the Society of CLU and ChFC.

• Recourse

Continued from Page 9

condition," he added.

Other people share the same problem. Those who have had drug or alcohol treatment and older individuals fit into similar categories.

Other than a little bit of cancer, I'm in fairly decent health (a little high blood pressure maybe). While I feel like an old man (the name is not Erma by the way — it's Hungarian and probably developed during the era of Conan) at 28, most tell me I've got a way to go.

But I would have some recourse. I could fall into the uninsured category or get into a group plan (thank god I'm already in one) and become its high-risk centerpiece. In that case, the other healthy members of the group would pick up the costs.

This also opens up another issue — that of an increasing trend (albeit small) by employers requiring a physical and medical history prior to hiring prospective employees. Many employers are already letting medical coverage be an individual thing.

It makes me worry. But what the hell, at least I have a plan now and the cancer said later on for the time being.

3, 1989

• Increasing competition

Continued from Page 15

Of cost shopping, Clark says, "Everybody's entitled to transportation but not everybody's entitled to drive a BMW." In some cases, Blue Cross is allowing patients to receive care in the home in lieu of costlier hospital care where applicable.

Clark said the idea of a built in fee system is to increase the competition level in the industry. He said he'd also like to see it reduce the amount of what he called "defensive" costs where a doctor orders second and third tests that tell him essentially the same data due to malpractice worries.

Roller said the state looked at the option of going self insured for its employees and found that it wouldn't do any good. The finding further reinforced his perception that the insurance companies weren't out to make a killing but just out to cover costs incurred.

• Health: insurers have little control

Continued from Page 9

can peg on one scapegoat, but a number of serious factors contribute, he added.

"In the old days, you picked one guy and called it a hospital problem," he said. "You can't do that anymore. Employers, unions, the medical profession, the insured ... they all have to get involved as well. If we are to contain the excessive costs of health care in Alaska, we've got to work in unison with the physicians, hospitals, employers and individual subscribers to reach a consensus on how to remedy a situation where individuals are being priced out of health care benefits. Everybody involved has to be willing to make changes."

He admitted his request for a rate increase won't solve the problem.

"It just finances it for one more year," Clark said while on a trip through Alaska last month.

Blue Cross, as well as Aetna, has studied the problem in depth. Aetna shared its findings with the governor's Health Insurance Task Force underlining some of the causes for increases and the severity of the situation facing the state. Blue Cross reviewed claim histories to come up with a picture of the industry. Its study suggests measures must be taken to contain cost increases or more individuals will fall in that uncovered realm.

"Something is seriously amiss," Roller said. "We're obviously spending an adequate amount but it's not being distributed equally. As people start to drop out of the health insurance area, that in turn drives up costs even higher and that spreads risks among a smaller and smaller pool."

Roller said many tend to blame the insurers but that's not the case.

"They don't have much control," he said.

According to figures researched by Hewitt Associates, 33 percent of the projected increases in health care premiums could be attributed to medical inflation, 29.5 percent to cost-

shifting from cut federal programs, 16 percent to utilization of services, 11 percent to technology with the rest going to catastrophic and malpractice cases.

Roller points to cost shifting as one of the more overlooked causes which is primarily due to the result of the federal government capping programs that provide coverage. Because of that, Medicare and other government subsidies pay a set amount for certain illnesses and services. As a result, insurance carriers pay more and shift the increased costs that fall on them to the rest of their subscribers.

"That point needs to be brought home," Roller said. "It's not just hitting Alaska but it's endemic throughout the country."

He also says health insurance is really a misnomer. Insurance companies act more and more like administrators. They pay the bills which come in at a predictable rate. At the end of the year, reviewers with docto-



rates calculate the costs and schedule rates accordingly.

"It's kind of like insuring yourself for buying gasoline," he said. "You know you're going to need it."

Dental insurance is a good example. Most people can expect a couple of routine visits a year, he adds.

Wagstaff said medical insurance is very service oriented and provides it chiefly because his clients require it and because it's part of business insurance planning. His firm specializes in all forms of employee benefits insurance products.

Solutions are being sought after by the state as well as a number of carriers. As a first step, Blue Cross is building a what it calls a realistic fee schedule and assisting its clients in finding the most cost-effective care. Clark calls it putting more power back into the hands of the consumer.

"We don't have the answers yet," he said. "We're getting back to the basics."

Roller said the Health Insurance Task Force looked into setting up a utilization review middleman to recommend low-cost services to the in-

See INCREASING, Page 20

INSURANCE UPDATE

Part 1 PERSONAL COVERAGE



Health insurance rates will go higher

By IMRE NEMETH

Health insurance rates are high and projected to escalate further with no real end in sight. The reasons for this are debatable, of course, but contributing factors pegged are medical inflation, user cost apathy, federal program cutbacks, technology and catastrophic cases.

Stephen Clark, vice president and chief operating officer at Blue Cross of Washington and Alaska, proposed a 70 percent increase on certain Alaska plans just to cover costs. Two of four of its individual health plans are targeted for the hefty hike with others planned for smaller increases.

Paul Roller, director of the state Division of Insurance, says other carriers are proposing increases as high as 102 percent. While the proposals may appear high, Roller figures his market analysts will probably find many justified and allow increases similar to those proposed.

There's a trend by health-care providers to move subscribers into plans with higher deductibles and limits on service. The riders of the past and even the so-called "Cadillac" plans are being trimmed. It's not to the level of a 1968 Volkswagon beetle but the new typical plan could very well be likened to the self described sensible Hyundai.

Plans with the lowest deductibles — from \$100 to \$200 — are typically getting the most attention by insurance companies and the lion's share of increases.

Almost like a travel agent who electronically calls up every fare on the planet when tracking the cheap-

est route between two points, Paul Wagstaff's Northwest Planning Associates computer system digs into the industry for the best plan for a particular client. He estimates the number of plans available at between 1,400 and 1,500 among the as many as 200 different carriers.

Using the data and specifics provided by a typical business shopping for a plan for its employees, he then

comes up with a slate of possibilities. The ensuing spectrum of plans comparing cost per month and available coverage then provides the choice.

Wagstaff says the shopping process is a constant. He attributes it to employers routinely looking at a yearly rate increase.

"There's a trend to more skeletal plans," he said. "People are getting down to the basics and deleting op-

of the cost. What is shaping out of this is a definite trend toward the higher deductible. It's those plans with sizeable deductibles that experience the least amount of yearly increase — in the 12 percent to 15 percent range as opposed to 25 percent and up.

Clark is tired of spiraling rates. He'd like to see measures taken that put a cap on the problem.

Moving to the Bahamas and working on a professional tan 12 months out of the year was out, so he went for the next best thing — Clark decided to hammer at the causes. He figures if he can't kick rates in the teeth, he might be able to forestall the continuing trend of astronomic annual hikes.

"It's a national problem," Clark said.

In the United States, health care consumes 11 percent of the gross national product. The country's medical system and quality of care is considered among the best in the world, but there's an increasing number of people who don't have medical coverage. These individuals who slip through the cracks also need attention in case of illness. When they do have something happen and spend time in the hospital, they end up forcing costs higher on those who pay. By contrast, in Japan and most of Western Europe where health care is universally available, health care takes up 3.5 percent of their gross national product.

Clark said the first step in the battle is calling awareness to the problem and getting everybody involved. It's not just something consumers

So you've a problem

By IMRE NEMETH

In late October of last year, my doctor said, "You've got a tumor, it could be cancerous. I want you on the operating table tomorrow."

I wasn't too impressed.

Nonetheless, two days later, I felt like a 1933 Willys that just had it's roof chopped two inches. Something was missing. Then the doc (who wasn't much for humor) told me this tumor (which I had grown attached to) was malignant and that I could expect treatment.

Not fun. Expensive too. In a few weeks, I racked up nearly \$15,000 in bills and I glowed in the dark.

Little did I know then, but I entered the realm of high-risk health care individuals. If I were to ask an insurance carrier today for individual coverage at a good

price, the staffer handling the call could conceivably hold up a crucifix and back slowly out of the room. Or they may just say no.

I asked Paul Wagstaff, owner of Northwest Planning Associates, what my chances were.

"You'd have a very difficult time getting insurance," he said simply.

Insurance carriers base plan rates on group or individual claims history. They function as a business much like any other and must make a profit. Risk is not something they consider too cool.

Wagstaff said most would like to wait and see if I developed any more problems. It would probably take five years, he said.

"At best they would rider the

See RECOURSE, Page 14

MAR 16 1989

3531 West 31st Avenue
Anchorage, Alaska 99517

March 14th, 1989

WEST ANCHORAGE LEGISLATORS
Senators Pat Rodey & Drue Pearce
Representatives Alyce Hanley,
Max Gruenberg, Dave Donley & Loren Leman

Jo - Let's plug him into
the Task Force -

give this to
members - let
Frank know what's
happening.

Dear Drue,

During the March 2nd Turnagain Community Council teleconference I had an opportunity to tell you that, as a life and health insurance salesman:

...I believe we have reached a crisis stage insofar as the availability of affordable health insurance and health care is concerned.

...I have some recommendations for those legislators charged with bringing the cost of health insurance for State of Alaska employees under control.

The costs for health care and health insurance, the usage rate for health services, and cost shifting are all factors which must be brought under control. I believe that the State of Alaska must serve as a catalyst in bringing together qualified people from the medical professions, insurance industry, consumer groups and social services organizations to look for solutions. I do not believe they will find any unless (1) they are all really determined to do so, (2) they are all prepared to consider some radically new ideas, and (3) they are all willing to give up some of the things they have become used to. I urge you all to do what you can to establish this forum.

Every day I talk to responsible people who want to stand on their own two feet and fund their future health care expenses through insurance. For many the cost of doing this today has become a serious burden and for others it has become an impossible objective. All are faced with difficult decisions in selecting what they can and should insure. I have spoken to no one in the private sector who does not resent the level of health insurance which the State of Alaska continues to provide its employees. In negotiating an affordable level of benefits with union representatives, the message in the previous sentence should be transmitted loudly and clearly.

I see three areas in which savings may be found in the state group insurance program:

Rate Structure From what I have read in the newspapers, the State of Alaska now pays \$431 per month per state employee. This is the rate if the employee is single and it is the rate if the employee has a spouse or a child (or children) or a spouse and a child (or childrer). This was probably the most cost effective way of rating the entire group at some time in the past but it may not be the best way today. There are any number of ways to "rate out" a group and I think it would be appropriate to ask your carrier to produce rates using different combinations. If changes

are made in the employee contribution level (presently "zero") or the plan design it would be appropriate to (1) communicate these changes to all employees, (2) run a survey to determine the likely level of participation following the changes, and (3) ask your carrier to recalculate the various rating structures using the new census.

Employee Participation in Premium Payments I have enclosed a reprint of three articles from the February 6th edition of the Alaska Journal of Commerce. David Stratton's article - Health Costs Not Evident to Consumer - contains a message that we must all understand. State employees can now insure themselves and their dependents on the group plan whether they need insurance or not. In an enclosed paper "Coordination of Benefits and Double Coverage," I have presented information which may assist you in evaluating a requirement for employee contributions towards the cost of their own and their dependents' insurance.

Plan Design The information in Mr. Stratton's article is also pertinent in developing an appropriate plan design. I will not presume to suggest a plan design for State of Alaska employees. I will suggest that increased participation in the cost of health care through changes in plan design can be as beneficial in eliminating unnecessary expenditures as a requirement to participate in the cost of premiums. I have provided a list of plan features which, if changed, may result in savings. I should add that insurance carriers weigh the cost of a given feature in different ways (usually as a result of their own experience) and that it is unreasonable to expect any carrier to be able to change its plan in all of the ways I have listed.

I hope you find this information useful. If I may provide additional information, please contact me. My phone number at work is 257-5239. At home it is 243-2928.

Thank you all for the efforts you are making on behalf of all of us. I look forward to hearing from you at the future Turnagain Community Council teleconferences.

Sincerely,



Frank Keen

cc. Senator Sturgulewski
Senator Binkley
Senator Uehling
Senator Fischer
Representative Hoffman
Representative Larson
Representative Ellis

STATE OF ALASKA
HEALTH CARE COST CONTAINMENT
TASK FORCE
REPORT TO THE LEGISLATURE

By

Senator Tim Kelly, Chair
Representative Mike Navarre, Vice Chair
Senator Jim Duncan
Representative Mark Boyer
Michelle Castanedo
Bruce Cummings
Barbara Huff
Don Hitchcock
Karen Perdue
Greg O'Claray

January 31, 1990

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SECTION I

CREATION OF THE

HEALTH CARE COST CONTAINMENT TASK FORCE

SECTION I

CREATION OF THE HEALTH COST CARE CONTAINMENT TASK FORCE

Several events occurred at the beginning of the Sixteenth Alaska State Legislature that drew attention to the escalating costs of health insurance for State employees, retirees, and their dependents. The first was the announcement of a substantial mid-year premium increase in order to cover the increased costs and utilization of State health care plans. The supplemental appropriation bill introduced to pay the additional premium costs for the fiscal year (FY 89) budget alone was \$21,800,000.

Particularly alarming was the aspect that the additional premium needed followed large premium increases in the preceding two years with essentially no changes to the health plans. In effect, the cost of State employee health benefit coverage has increased 54% over the last three years. Legislative finance committees had earlier expressed their concern by requesting the Division of Retirement and Benefits to make recommendations that the Legislature could take to limit costs. The initial reaction of many finance committee members to the new funding request was negative or confrontational.

State employee union representatives had also expressed concern. Several of the bargaining units were in negotiations with the State over wages and benefits, wherein, the health care cost increases presented a complicating factor. From their perspective, rising health care costs was a continuing problem throughout the nation that has been confronted successfully in the private and other public sectors with appropriate cost management of health plans. Furthermore, they expressed a willingness to assist the Administration and the Legislature in determining cost containment provisions that could readily and effectively apply to the State's health care situation.

With consenting agreement between the Governor and the House and Senate leadership, Senate Concurrent Resolution 23 was introduced on February 23, 1989 to create a task force made up of legislators, public employee representatives, and representatives of the Administration. Their task was to review all aspects of health care cost containment and make recommendations that would reduce the supplemental funding request.

Secondly, the task force was to determine actions that would contend with health cost inflation in the long term. Testimony before the Senate Finance Committee on February 24, 1989 asserted that there was in fact means to help reduce the costs of the State health care plan. Possible areas of savings that were outlined included: cost containment provisions could be incorporated into the plan without changing existing benefits, review of the plan's financial status, alternate funding of the plan, and provider payment schedules. Several items could be implemented to impact the FY 89 budget, with the remainder to reduce health care costs in FY 90 and beyond.

On March 10, 1989, SCR 23 had passed both houses of the Legislature and became Legislative Resolve 8. Appointments to the Task Force were quickly made and the Task Force began work on March 22, 1989. The Task Force retained A.J. Gallagher & Co. to provide health care consulting and actuarial services.

The following is a report of the work and activities of the Health Care Cost Containment Task Force. This report describes the findings, results, and recommendations designed to achieve a more cost efficient State of Alaska Health Care Benefit System for employees, retirees and their dependents.

SECTION II

HEALTH CARE COST CONTAINMENT TASK FORCE

GOALS AND OBJECTIVES

SECTION II

HEALTH CARE COST CONTAINMENT TASK FORCE

GOALS AND OBJECTIVES

SHORT RANGE

The Task Force was charged with the responsibility of identifying ways to reduce the FY 89 health care cost supplemental funding request. The Task Force looked at ways to immediately reduce the cost to the State and, in return, reduce the supplemental funding request to cover premium increases. The short range review focused on three specific areas:

- Funding of the plan.
- Plan Design.
- Procedural or legislative changes that would reduce costs.

MID-RANGE

The Task Force was charged with determining appropriate cost containment measures that could be implemented, without interfering with collective bargaining prerogatives, to reduce health care cost to the State for FY 90 and beyond. The mid-range review focused on several areas:

- Cost containment measures that would monitor and assure that the most cost beneficial health care delivered to participants.

- Methods to revise the health plan designs to keep it in line with general trends and changes in the health care delivery systems.
- Educational and wellness programs to effect long-term health improvement strategies and identify long range cost containment goals.

LONG RANGE

The Task Force sought to identify ways to control or curb rising health care provider charges, assure quality of care, and restrict actions that shift additional costs to the State plan. The Task Force has identified means to reduce or slow medical inflation of State health plans over the long term. The areas that have been determined to require further study are:

- Alternate financing of the plan (partially self-funded, etc.).
- Purchasing groups (i.e., Preferred Provider Organization-P.P.O.-or buying coalitions) to coordinate the health care purchasing power of the State in order to assure appropriate costs and proper benefit delivery to participants.
- Provider payment schedules in lieu of the current, usual, customary and reasonable schedules (UCR).
- Pooling or trusting of health care benefit plans.
- Impact of state or federal legislation that dictates cost shifting from other programs to State plans.

SECTION III

OVERVIEW OF STATE HEALTH BENEFIT PLANS

(ACTIVES AND RETIREES)

SECTION III

OVERVIEW OF STATE HEALTH BENEFITS PLANS

(ACTIVEES AND RETIREES)

The base medical plan covers approximately 13,000 active employees, and an estimated 17,500 dependents for medical, dental, vision and audio coverage. Prior to December 1, 1989, there were nine plan designs for each of the separate bargaining units all covered under one master contract with the Aetna Insurance Company.

Effective December 1, 1989, all of the plans have come under one common plan design, including non-bargained and union employees. Cost containment measures were implemented on December 1, 1989. This was accomplished utilizing Task Force recommendations, collective bargaining negotiations between the State and the Alaska State Employees' Association (ASEA), along with the "me too" clause in other labor contracts. A summary of the new plan is presented in Exhibit A. It should be noted that the new plan is still subject to a ratification vote of ASEA employees.

Under a separate plan design, approximately 10,500 retirees and an estimated 9,800 dependents are covered for medical only. Retirees can be former members of the Public Employees' Retirement System (PERS), the Teacher's Retirement System (TRS), the Judicial Retirement System (JRS), or the Elected Public Officer's Retirement System (EPORS).

Retirees have the option of having dental, vision and audio coverage with the premium being deducted from their retirement checks, if they elect to do so following 60 days of their retirement. A description of coverages provided to retirees is outlined in Exhibit B.

The Supplemental Benefits System (SBS) is available to all eligible active employees of the State of Alaska, where the employee can choose additional

coverage and pay premiums out of the Alaska Social Security Fund. SBS covers the deductible and the wellness or prevention care programs. Open enrollment occurs in October for the plan year effective the following February. There are two SBS coverage options (Exhibit C). Currently, 8,900 employees are enrolled in Option I and slightly over 400 enrolled in Option II.

DESCRIPTION OF AETNA SERVICES

Aetna Insurance Company provides a fully insured plan for both the active and the retiree plans. Although, the two plans are governed under separate contract, there appeared to be a financial link between the two plans upon termination of the Aetna contracts. The link was a provision that allowed the cross application of deficits or surpluses between the two plans. Upon recommendation of the Task Force, the State and Aetna agreed to keep the two plans completely separate.

Aetna Insurance Company services the State's plan from Seattle, Washington, where the claim processors, cost containment and service of the plan are handled on a day-to-day basis. There are currently 46 Seattle-based Aetna employees dedicated exclusively to the State of Alaska plan. They include: claim processors, nurses, cost containment specialists, customer service representatives, clerical, supervisors, and account executives.

Financial and accounting services for the State of Alaska plan are handled out of the Aetna western home office, located in Walnut Creek, California. The Walnut Creek office provides for renewals, financial projections and costing of revisions as necessary for the plan.

The home office of the Aetna Insurance Company (based in Hartford, Connecticut) receives the eligibility and premium payments. Aetna then allocates the funds to the appropriate accounts and verifies coverage for the eligible individuals.

Under the fully insured plans, the State pays a fixed premium to Aetna, where Aetna assumes the risk and settles claims for the participants. The plan is fully experience-rated, whereby future rates are based on claims paid under the State's plan. It should be noted that the financial accounting for the plan is run on a fiscal year basis coinciding with the State's fiscal year; however, the rates change on February 1st of each year. Originally, the rate change and the financial accounting coincided; however, due to prolonged and

proposed plan changes over the past several years, the actual rate change has been shifted to February 1st of each year. Aetna is required to produce rate changes and financial accounting to the State during the month of October, preceding the proposed renewal date in February. This leads to some confusion as the claims and accounting data are on a slightly different basis than when the premium is collected. In years when there is no premium increase, it has less of an effect than in years when there is a substantial increase projected. The increases lag the claims data by seven months.

Aetna has been under contract with the State of Alaska since 1981. The contract was rebid in 1987 for a three year duration with the possibility of two one-year extensions. In 1987, the rebid attracted only one respondent, Aetna.

COST EXPERIENCE

Tables I and II display the monthly premium cost over the years for each entity covered under the medical plans. Please note that the financial accounting period and the fiscal year of the State do not coincide; therefore, the discrepancy for two rates in a single year. The aggregate of claims experience is presented in Table III.

INPATIENT AND OUTPATIENT BENEFITS

Total inpatient and outpatient benefits payable increased 12.95 percent from policy year 1987 to 1988. The detailed breakdown of these increases is presented in Exhibit D.

Inpatient benefits payable (regular benefits payable by the plan, after deductibles and coinsurances) increased 11.12 percent from 1987 to 1988 of which hospital room and board increased 14.57 percent. Mental and nervous benefits payable increased 27.34 percent during this period, which represents 10.6 percent and 12.14 percent of inpatient benefits payable in 1987 and 1988, respectively.

Outpatient benefits payable increased 14.57 percent from 1987 to 1988. Benefits payable for outpatient facilities increased 72.22 percent during the same period, while ancillary increased 22.97 percent. (See Percent Changes in Benefits Payable). Mental and nervous/substance abuse increased 8.69 percent.

TABLE I

**MONTHLY HEALTH INSURANCE PREMIUMS
BY COVERED ENTITY
(ACTIVE EMPLOYEE PLAN)**

	FY84	FY85	FY86	FY87	FY88	FY89	2/89 a	12/89 b	2/90 c
General Gov't Unit	\$217.65	\$217.65	\$224.20	\$242.15	\$307.53	\$411.16	\$431.72	\$384.59	\$384.59
Non-Covered Employees	217.65	217.65	224.20	242.15	307.53	411.16	431.72	↓ ↓ ↓ ↓ ↓ ↓ ↓ ↓ ↓ ↓	↓ ↓ ↓ ↓ ↓ ↓ ↓ ↓ ↓ ↓
Local 71	186.51	230.84	237.75	256.80	326.14	421.75	442.84		
IBU (begin 11/83)	184.57	184.57	224.20	242.15	307.53	411.16	431.72		
MMP (begin 7/85)	N/A	N/A	237.75	256.80	326.14	427.41	448.78		
MEBA	234.84	234.84	250.45	270.50	343.54	461.88	484.97		
CCSEA	217.65	217.65	224.20	242.15	307.53	411.16	431.72		
Supervisory	230.84	230.84	237.75	256.80	326.14	427.41	448.78		
Confidential	230.84	230.84	237.75	256.80	326.14	427.41	448.78		
PSEA	216.12	216.12	222.60	240.90	305.94	411.16	431.72		

(a) Renewal

(b) Cost Containment Implementation

(c) Renewal with Cost Containment

TABLE II

MONTHLY HEALTH INSURANCE PREMIUMS
RETIREES

FY84	FY85	FY86	FY87 7/86-10/87	FY88 11/87-6/88	FY89 7/88-1/89	FY90 2/89-1/90	FY90/91 2/90-1/91
\$156.07	\$191.85	\$175.00	\$165.00	\$140.25	\$211.22	\$252.83	\$243.98

TABLE III

STATE OF ALASKA
ACTIVE EMPLOYEE EXPERIENCE

<u>Policy Year</u>	<u>Paid Premium</u>	<u>Incurred Claims</u>	<u>Retention</u>	<u>Policy Year Surplus (Deficit)</u>	<u>Cumulative Balance</u>
7/82 - 7/83	\$27,729,375	\$25,312,455	\$1,586,818	\$ 830,102	\$ 830,102
7/83 - 7/84	27,857,503	23,619,520	684,501	3,553,482	4,383,584
7/84 - 7/85	34,763,000	32,223,711	770,849	1,768,440	6,152,024
7/85 - 7/86	36,756,000	38,378,681	871,457	(2,494,138)	3,657,886
7/86 - 7/87	39,484,110	44,113,812	1,526,215	(6,155,917)	(2,498,031)
7/87 - 7/88	47,004,042	48,171,397	2,210,804	(3,378,159)	(5,876,190)
7/88 - 7/89	67,580,599	49,502,164	2,185,030	17,603,865*	4,279,836

RETIRED EMPLOYEE EXPERIENCE

<u>Policy Year</u>	<u>Paid Premium</u>	<u>Incurred Claims</u>	<u>Retention</u>	<u>Policy Year Surplus (Deficit)</u>	<u>Cumulative Balance</u>
7/82 - 7/83	\$ 6,440,213	\$ 8,146,246	\$ 377,676	\$(2,083,709)	\$(2,083,709)
7/83 - 7/84	10,274,521	7,275,641	258,989	2,739,891	656,182
7/84 - 7/85	13,848,779	9,456,773	254,484	4,137,522	4,793,704
7/85 - 7/86	14,011,340	11,092,724	353,460	2,565,156	7,358,860
7/86 - 7/87	15,500,815	12,621,468	568,806	2,310,541	9,669,401
7/87 - 7/88	17,296,636	19,881,727	869,340	(3,454,431)	5,558,415
7/88 - 7/89	27,078,313	21,257,624	1,042,751	5,656,150	11,214,565

*Includes refund of \$3,698,336.

Hospital ancillary (which includes mental and substance abuse disorders) continues to represent the largest percentage of inpatient and total benefits payable for plan years 1987 and 1988, at 42.56 percent and 43.19 percent, respectively.

On an outpatient basis, ancillary benefits represent 18.99 percent and 10.06 percent of outpatient and total benefits payable, respectively.

Medical benefits is the most significant outpatient service at 20.28 percent of outpatient and 10.74 percent of total benefits payable, respectively.

RANGE OF EXPENSE REPORT

Generally, the occurrence of claimants within the various cost ranges are relatively consistent from one year to the next.

During the calendar years 1987, 1988 and 1989, the majority of claims (between 66.65 percent and 69.94 percent) fall within the \$10,000 to \$20,000 range.

In calendar years 1987 and 1988, the number in the \$50,000 to \$100,000 range increased almost 65 percent from 42 to 69. Based on annualized data for calendar year 1989, this range appears to normalize back to approximately the 1987 level.

INPATIENT CONFINEMENTS IN EXCESS OF \$50,000

Benefits payable for inpatient confinements in excess of \$50,000 as a total inpatient benefits payable increased slightly from plan year 1987 to plan year 1988 (11.15 percent to 12.14 percent), while the actual dollar increased over 20 percent. The most significant increase was in the Son of Participant category, where 11 participants (10 more than the 1987 plan year) had a medical condition that generated over \$50,000 in benefits payable, ranging from \$51,767 (extreme immaturity) to \$145,740 (pre-term infant), and amounting to almost \$850,000. During plan year 1987, there was one claim that amounted to just over \$62,000.

SECTION IV

FINDINGS, RESULTS AND RECOMMENDATIONS

OF THE

HEALTH CARE COST CONTAINMENT TASK FORCE

SECTION IV

FINDINGS, RESULTS AND RECOMMENDATIONS

OF THE

HEALTH CARE COST CONTAINMENT TASK FORCE

SHORT RANGE -- MARCH 1989 TO MAY 1989

- A. **Financial Reviews of Plans.** Premium Taxes --Aetna would charge the State's plan for premium taxes and credit the plan experience once a refund was received from the Department of Revenue. This procedure would not normally effect the State's rates, however, (plan expenses) were overstated by \$1.8 million (\$1,147,379 for activees and \$667,978 for retirees) due to a delay in crediting the refund.

The Task Force requested the Department of Administration to procure a refund from Aetna for this amount. This refund was applied to reduce the supplemental funding request. The active plan received a refund of \$1,147,374 and the retiree plan received a \$667,978 refund.

- B. **Legislation.** The Task Force recommended that the Legislature revise AS 39.30 to exempt the payment of premium taxes on the State's health plan and eliminate the possibility of a future expense charge to the plan expenses.

HB 264 am was enacted on May 8, 1989 effecting this change.

- C. **Extended Liability Reserve.** As a part of Aetna's standard operating procedure, a separate reserve is established for "extended liability." The purpose of the extended liability reserve is for claims incurred by an individual on disability at the time of a prospective contract termination (Aetna's). Plans can eliminate the extended liability reserve. If they change from one carrier to another, the new carrier could accept the liability.

Aetna was holding \$3,697,724 as of June, 1988 for this liability and agreed to release 80% of the monies to the State, if the State accepted the liability.

The Task Force recommended that the Department of Administration assume the liability and recover \$2.4 million to help reduce the supplemental funding request.

- D. **Financial Experience.** The State's financial experience was reviewed to determine if the reserves, expenses (retention) and deficit/surplus were in accordance with the contract.

The Task Force found that the reserves were set within actuarially accepted levels.

Plan expenses were running less than 7.0% (before interest offsets). It was, however, found that previous years when the plan was in a surplus position, the rates could have been reduced or a refund could have been generated to the State, as opposed to being held by Aetna.

In 1989, the active employees' plan had a surplus of \$4,279,836 (see Table III). The implementation of cost containment provisions and good experience, enabled the State to negotiate the current rate of \$384.59 to be guaranteed for an additional 12 months.

The retiree plan has a current surplus of \$11,241,565 less the claim fluctuation margin of \$1,464,374 for a net balance of \$9,750,191. The net balance could be used to reduce premium rates.

- E. **Drafts Versus Checks.** Alaska State Law (AS 21.89.03) requires that an insurance company use a negotiable bank check to settle a claim or pay a judgment. This means that Aetna issues checks on a funded account. Usually, minimum premium or self-funded plans issue drafts that are funded upon presentation. This change from checks to drafts would result in an additional ten day float on the money, resulting in a net interest credit to the State. There are some administrative and banking arrangements that need to be established to take advantage of this.

The Task Force recommended revision of AS 21.89.03. SB 257 and HB 265 were introduced for the State to take advantage of this interest credit.

- F. **Supplemental Benefits System (Plans I & II).** Prior to fiscal year 1989, the Supplemental Benefits System experience or (cost) was not maintained separate from general health plan experience. Therefore, it had not been possible to ascertain the actual and appropriate premium rates.

The Task Force recommended separate experience results with the financial accounting period ending June 30, 1989. The plan experience has been separated and the SBS option has been rated much closer to what the actual cost is.

A second concern of the Task Force was that the Supplemental Benefits System raises the level of benefits to the participants and, therefore, may increase utilization. This possibility heightened the importance to separate the experience and limit the shifting of costs to the base plan. Separation of

experience would provide for the SBS and the base medical plan to be responsible for their appropriate share of costs. Effective February 1, 1990, the SBS plan will have a 53% increase, while there was no increase necessary for the regular medical plan.

- G. **Audit.** In the nine years that the State plan has been covered by Aetna, there has never been an audit of the carrier's performance. To evaluate the performance and quality assurance factors that are contractually agreed to. The Task Force had recommended that the Division of Retirement & Benefits should institute a complete audit of Aetna's procedures and claims operations. The Division of Retirement & Benefits contracted with Deloitte & Touche to audit Aetna's claims operation. The audit report was delivered in December, 1989.

CONCLUSION

The initial supplemental request for FY 89 (\$21,800,000) was subsequently reduced to \$12,300,000 through finance committee budget work. The \$7,200,000 general fund portion of this latter figure was offset by \$3,500,000 through Task Force identified refunds. In effect, the FY 89 general fund requirement for the health care cost increase was reduced to \$3,700,000.

An additional \$700,000 of refunds was returned to retiree pension funds.

RESULTS AND RECOMMENDATIONS

MID-RANGE -- MAY 1989 THROUGH DECEMBER 1989

The Task Force identified over 20 items that would help reduce health care cost in fiscal year 1990 and beyond.

The most significant areas of potential savings were cost containment provisions in the operation of the health care plan and negotiated fee arrangements with health care providers. The Task Force identified the following cost containment provisions that could be implemented by agreement between labor and management without effecting negotiated benefits.

***Utilization Review** - Provides ongoing review for reasonableness of treatment and costs;

***Pre-admission Certification** - Requires pre-certification for all hospital admissions, reduces inpatient hospital stays, and provides alternate treatment sites where more cost effective;

***Outpatient Pre-certification** - Requires pre-certification for all outpatient surgeries or procedures over a pre-determined level, reduces unnecessary procedures or limits expensive procedures;

***Managed Mental Health/E.A.P.** - Helps guide participant to appropriate treatment and intervention/prevention by using an employee assistance program as a referral to treatment;

***Expanded Large Case Management** - By knowing about a claim early on (via pre-certification), the Health Care Coordinator can review the claim for possibly more efficient care setting at a lower cost to the plan.

***Consumer Advisory Service** - Provides a health resource to all participants regarding claims, procedures or questions giving the participants an ally in the "system".

***High Risk Pregnancy Management** - This program is designed to lower the incidence of low birth weight (LBW) infants born to female employees and dependents. Can reduce or eliminate high cost of premature deliveries;

***Managed Second Surgical Opinion** - Operates similarly to the pre-certification factor system, whereby listed surgical procedures requires a second opinion to find out whether the surgery is necessary or an alternative method could be used at a lower cost;

***On-Site Concurrent Review** - The On-Site Concurrent Review Program is designed to assure that medically necessary care is provided in an efficient manner. A registered nurse visits hospitalized patients daily and reviews the patient's hospital charts. Provides sentinel effect on hospitals lowering overall inpatient costs;

***Vision Plan P.P.O.** - Provides plan members with the option of receiving care from a preferred provider. The participant receives improved benefits while the plan is billed at a discount for services;

***R & C Profile** - Reasonable and Customary (R & C) profiles represent the prevailing charge made by health care providers of similar expertise for a similar procedure in a particular geographic area. These are currently set every six months for the State. Aetna states they are paying 90% of R & C. The profiles could be revised every 12, 18 or 24 months to slow medical inflation within the plan;

***Wellness Programs** - Wellness Programs are comprised of topics designed to promote safety and good health among employees, including physical fitness programs. A long range approach to controlling medical costs through prevention;

***Mail Order Drug Program** - The Mail Order Drug Program offers a cost saving, convenience service for obtaining prescription drugs through the mail. Drugs are dispensed up to a ninety day supply instead of a thirty day supply. This program is ideal for patients receiving maintenance treatment, which account for up to 70% of all prescription drug costs. Additional savings would be realized by substituting generic drugs for brand names drugs.

***Eligibility/Enrollment Verification** - It was recommended that all participants re-enroll in the plan to ensure that the eligibility of employees, retirees and their dependents and other insurance plan information was current. The last complete enrollment was in 1983.

***Management Reports/Participant Demographics** - Management reports provide the necessary information for the effective management of the health care program. Effective reports help to identify trends and patterns in charges and utilization; pinpoint specific sources of experience; design plan changes and monitor the results of plan changes. Current reports need revisions to accurately track plan experience on a timely basis.

As of December 1, 1989 all recommendations were implemented with the exception of managed mental health, R & C profiles and wellness programs. The total savings generated by these cost containment provisions in conjunction with negotiated benefit changes is approximately \$7,000,000 for calendar year 1990 (for active employees). These measures also helped provide the State with a favorable renewal from Aetna, whereby the revised premium rate of \$384.59 will be guaranteed until February 1, 1991.

A similar but limited effect could be achieved for the retiree's plan. The limit is the State constitutional treatment of an employee's retirement benefits as a contractual right (from the first day of employment). The State cannot act to reduce or impair that right. It is the impairment question that needs legal

definition. Accordingly, the Task Force has requested an Attorney General's opinion on which cost containment provisions may be implemented and withstand challenge. It is expected that provisions such as utilization review and periodic re-enrollments are acceptable, whereas pre-certification and second surgical opinions require close legal scrutiny.

The Task Force anticipates affecting in the near future some cost containment provisions for the retiree's plan which will reduce the health care cost obligations of the pension funds.

LONG RANGE CONSIDERATION OF THE HEALTH CARE COST CONTAINMENT TASK FORCE

While the Task Force has achieved particular success in reducing the supplemental funding request and reducing the FY 90 cost of the State's health plan, the inflationary trends of medical costs in Alaska portend future increases for the State. Indeed, the State will be paying in excess of \$300 million in FY 90 for health care payments of all types. This is an increase from \$75 million in 1980, a 300 percent increase over the past 10 years. Aetna's calculation of cost trend factors for the last three years has ranged from 14 percent to 23 percent.

It is with this view and concern that the Task Force identified several considerations to affect long-term strategies of minimizing medical inflation. These strategies are for the most part directed at the health provider industry itself. They utilize the State's size in both numbers and funding to health care providers to restrain or control medical inflation. These considerations also attempt to reduce direct cost shifting to the State from mandated benefit changes and federal program changes.

The following areas have been determined by the Task Force as needing further study and consideration in developing recommendations to the State.

1. Self-Insured Plan Options

Currently, the State purchases its State health care on a fully insured basis. The Task Force is presently investigating the funding alternatives, whereby the State could employ a variety of financing options in order to reduce the cost of the plan and keep premium dollars in Alaska until claims are paid. Exhibit E

illustrates the self-insured options that are available to the State at this time.

By utilizing alternate funding methods, the State could increase the flexibility by which it funds and pays benefits to participants. However, it must be noted that there would be some administrative expenses incurred as some of the record-keeping for the accounts would have to be handled internally by the State instead of the carrier.

The Task Force expects to issue a complete report regarding the advantages, disadvantages, and associated costs, with an estimate of the savings generated by alternate funding methods.

2. Health Care Purchasing Groups

The Task Force has determined that by utilizing buying groups, the State could effect substantial savings to its health care plans.

Currently, the State of Alaska is paying full retail price for medical and dental services. Just as the State does with other goods and services purchased in quantity, the State could negotiate with providers for a discounted rate.

The State can take advantage of current negotiated discounts by utilizing the P.P.O. arrangement through Aetna. There are several ways that the State can negotiate a discount. They include: contracting with a third party organization to negotiate on the State's behalf; or have the State of Alaska negotiate its own contracts, possibly in conjunction with the P.P.O. arrangement and contracting with a third party organization. These arrangements should include all forms of health care purchasing within Alaska, not just the employee benefit plan (e.g. Medicaid and Medicare).

If the State negotiates its own contracts, this generally offers the most flexibility. The State would establish the agreement and the relationship regardless of the claims paying operations. This could also be part of the pooling authorities scope.

Estimated Savings. Generally, negotiated discounts, have generated gross savings (before expenses) of 5 percent to 20

percent, depending on the service, locality and competition in the given area. Such arrangements could generate savings on the employee benefit plan alone of 1.7 million to 7.5 million dollars per year. The Task Force believes that negotiated discounts is an important consideration for containing the cost of medical care. The Task Force will continue to review the alternatives to determine feasibility of this important buying power. Necessarily, the feasibility will depend to an important degree on unique aspects of Alaska's health provider market, wherein many communities are served by one or few providers.

The Task Force recognizes that it is imperative that quality care is delivered to the participant on a cost efficient basis through the plan with negotiated discounts.

3. Provider Payment Schedules

The Task Force has identified provider payment schedules as a proven method effective in controlling health care costs and constraining long-term medical cost inflation. This strategy has been employed by the federal government through the Diagnostic Related Group System (DRG) and the Resource Based Relative Value System (RBRVS) which will be implemented in 1992.

In a further step to control costs, a payment schedule could also be employed by the State. This would be either a modified DRG, a RBRVS or a schedule specifically tailored to the State of Alaska's health care marketplace.

Essentially, under the DRG a schedule is predetermined for each procedure based on the diagnosis of the patient. Under RBRVS schedule, type of care, necessity of care, geographic area, and training of the physician are all taken into account. A system of this nature takes considerable lead time to implement. These payment schedules can only be effective, if:

- The schedule is set on a realistic basis;
- Modifiers are used to control cost shifting; and
- If utilization review is in place;
- Quality of care is assured; and
- Cost savings objectives are met.

Unless the payment system is carefully designed, cost shifting is likely to occur which would minimize overall savings.

The Task Force continues to review and consider alternatives in the way providers are paid (other than the customary, usual and reasonable basis). The Task Force will determine the savings generated by utilizing a provider payment system, and will make specific recommendations as to the type of system most appropriate and its overall operations and implementation.

4. Pooling Concepts

The Task Force is reviewing a cost containment strategy employed by many states called pooling. The purpose of pooling is to provide comprehensive group health insurance to a larger base of enrollment so that: the risk is spread out; health coverage is provided on the most economical basis; provides the maximum opportunity for cost containment when purchasing group health insurance through favorable payment schedules of providers and vendors; entity(ies) can employ a mechanism that provides benefits or coverages that may not be available or are too costly.

Generally, legislation is required to create an entity that provides the coverages needed and oversees the operation of those coverages effectively and in a cost efficient manner. Senate Bill 254, authored by Senator Duncan, has been introduced into legislation. This bill would create the Alaska State Group Health Insurance Authority which would enable the State of Alaska to offer pooled group health coverage to eligible state, municipal and school district employees.

Some of the advantages of pooling are:

- Economy of scale. Eliminate duplicate or multiple plan costs.
- Provides for plan flexibility, plan rating and risk sharing. Each sub-group could conceivably have a slightly different plan design and could be individually rated based on their experience.

However, the risk of large claims occurring could be shared within the pool to eliminate wide swings in experience.

- Data collection - Allows a simplified system for tracking claims, abnormalities or impacts on health care expenditures, instead of obtaining information from many different sources.
- Projection of future cost and trends. The data base would be valuable in projecting future costs and trends, so that the State could be proactive rather than reactive in the management of its health plans.

Pooling enables the State to combine many advantages including self-funding, utilizing the State's purchasing power to help negotiate and control health care cost, and provide benefits on a cost efficient and manageable basis.

The Task Force is currently reviewing other states that have enacted these programs in order to determine the advantages and disadvantages and complexities involved in setting up a pool for the State. It is anticipated that the savings would be generated in several areas:

- Simplification of administration could save 1% to 3%.
- Provider Payments Schedules and P.P.O. Agreements, 5% to 20%.
- Recognize trends and adjust quickly, 5% to 7%.
- In general, economies in a scale of 1% to 3%.

The greatest savings generated would be from the State becoming a cohesive buying group for health care. By increasing the size of the group, the State is better able to negotiate with providers of the service to afford the best possible care, proper utilization, and the maximum benefit to participants without impacting the plan negatively. It would also isolate the plan from an additional cost shifting from other sources, which have become a significant

factor in medical inflation in the State of Alaska.

5. Trusts

The Task Force is also investigating the feasibility of using a trust to provide benefits to employees of the State. A trust generally collects premiums and pays health and welfare benefits to participants. It is governed by a trust document and a board of trustees, which can be a variety of representation from fully elected to an equal management and union representation.

The State could either create a trust, join an existing trust, or allow the bargaining units to utilize their own trusts. It would operate on a similar basis as an Insurance Authority (pool) would, except that they may not require enabling legislation. They would require collective bargaining agreements. Generally, a trust provides benefits to participants only up to the contribution level of employers. Typically, they use cost containment provisions and preferred provider arrangements to control costs.

6. Wellness and Employee Assistance (EAP) Programs

The Task Force is continuing investigations into the value of wellness programs. Nationally, these types of programs are gaining more recognition as a successful long-term strategy to reduce work force health costs through encouraging health promoting activities and discouraging risk taking (e.g. smoking, excess weight, etc.). Recently, the Municipality of Anchorage and one of its union groups have initiated a wellness program that combines incentives for program participation.

THE IMPACT OF COST SHIFTING TO THE STATE'S HEALTH PLAN DUE TO FEDERAL OR STATE LEGISLATIVE CHANGES

Consistently, over the last 10 years, federal and state law changes have shifted expenses to the various State health plans due to program cutbacks, reallocation of resources, or reducing benefits payable under certain programs. An excellent example is the federal Medicare system. Medicare currently pays 75% for physician services on the basis of "usual, customary and

reasonable" charges. The difference between the amount Medicare pays a provider for his or her services and the actual charge often times is passed on to the non-Medicare paying patients. It is in this manner that the State health plans experience a cost shift to the State's plans from the Medicare program.

In the waning hours of this last session of Congress, substantial changes to the Medicaid/Medicare system were incorporated in the Omnibus Budget Reconciliation Act (OBRA 89). It is difficult to report with certainty all the ramifications. However, there are several features readily apparent:

- A relative value payment schedule (RBRVS) is mandated for Medicare for 1992. Studies to determine geographic area adjustment factors and volume statistics for the schedule will commence this year.
- The State is obliged to an expanded coverage of pregnant women and for children up to six years of age.
- The State is obligated for certain nursing training costs as well as making up the difference of reduced Medicaid expenditures for certain programs and services mandated in the Nursing Home Reform provisions of OBRA 87.

The initial estimates of fiscal impact to the State for the latter two are \$7,000,000 and \$1,400,000, respectively.

It is imperative that the State of Alaska monitor federal legislative and programmatic changes that would result in a shift or increase in the cost of providing benefits under the State programs. The Task Force recommends that a monitoring function be established to measure and predict the cost of such changes (particularly, the RBRVS implementation) and their effects on the State.

Conclusion

The Task Force recommends that the Legislature extend its existence to February 15, 1991. We recognize that the successes obtained in reducing State employee and retiree health care costs can only be viewed as a beginning. Much work has been done to understand the longer term implications and prospects for controlling medical cost inflation. There is much work remaining before a consensus approach can be creditably advanced. The work needs to be completed. The only questions are when and by whom. The current task force has functioned as a unique and cooperative blend of public employee, administrative and legislative interests that has had real success. Building on the existing knowledge base, much more can be achieved.

SECTION V
ATTACHMENTS

EXHIBIT A

BENEFIT SUMMARY FOR ACTIVE EMPLOYEES

(REVISED DECEMBER 1, 1989)

Variations in coverage were provided to the nine active employee groups and collective bargaining units which have been standardized as of December 1, 1989. Standardization of the plan effected certain groups who had orthodontia an "incentive" dental arrangement, and other plan variations relative to the general government group. The following is a summary of the basic health plan that is provided to employees of the State:

DEDUCTIBLE

\$100/\$300 per family

MEDICAL

The plan pays 90% of the first \$3,950, then 100% of covered medical expenses.

LIFETIME MAXIMUM BENEFIT

\$250,000; \$5,000 Automatic Yearly Restoration

PREEXISTING CONDITIONS

12 month limitation of \$1,000 on medical conditions which existed prior to the effective date of coverage.

TRAVEL

The plan reimburses receipted travel/lodging/meal expenses for pre-authorized pre-operation testing when one way travel distance exceeds 100 miles. Reimbursement is available only for the days of actual testing.

ALCOHOL/DRUG ABUSE

The plan pays 90% of these expenses, with a limitation of \$7,000 on outpatient services over a two year period.

MENTAL/NERVOUS DISORDERS

The plan pays 90% of inpatient expenses, 50% of counseling services up to \$2,500 annually.

EXHIBIT A

(continued)

PRESCRIPTION DRUGS

If a participating pharmacy is utilized, there is a \$5 copay per brand name prescription, and no copay for generic prescriptions; if a non-participating pharmacy is used the plan pays 100% after the applicable brand name copay.

MAIL ORDER DRUGS

\$2 copay for each brand name prescription, no copay for generic prescriptions. The plan deductible and coinsurance requirements are waived. Copay amounts do not apply either toward the calendar year deductible or the out-of-pocket limit.

DENTAL

\$25 annual deductible per covered individual, with a maximum of 3 deductibles per year which is applied to maintenance, and structural services. The plan pays 100% of preventative services (mouth X-rays once per year), 85% of maintenance services, 50% of structural services up to an annual maximum of \$1,500. Preauthorization required for dental procedures or treatment in excess of \$500.

VISION

\$5 copay per examination, \$10 copay for materials (lenses, frames). The plan covers one examination and one set of lenses every 12 months, one set of qualified frames every other year. Charges for non-covered items in excess of the maximum allowable limit are paid by the employee.

AUDIO

The plan pays 80% of an annual exam, 80% for hearing aids and services, \$800 limit over a three year period, no annual deductible.

EXHIBIT A

(continued)

CONVALESCENT FACILITY

The plan pays 100%, up to the semi-private room limit after the deductible is satisfied. Precertification is required, no prior hospital confinement is required. The convalescent facility confinement must be certified as being in lieu of acute care hospitalization. No maximum length/days of coverage applies.

HOME HEALTH CARE

After the deductible is satisfied, the plan pays 90% for up to 120 visits per year. Precertification is required, no prior hospital confinement required.

CHIROPRACTIC SERVICES

After the deductible is satisfied, the plan pays a maximum of \$750 per year per person.

COORDINATION OF BENEFITS

An accumulated calendar-year-to-date Maintenance of Benefits coordination applies to both the standard "external" Coordination of Benefits situation, where primary coverage is available through another employer's plan, as well as to duplicate coverage for working couples under the State of Alaska Plan. Children will be enrolled only under one parent's plan according to the birthday rule. Spouses will enroll separately, effective January 1, 1990.

PATIENT AUDITOR PROGRAM

A program that encourages patient participation in identifying services for which the patient did not receive treatment. The erroneous charges identified on a single bill or admission total a minimum of \$100. If an overcharge is verified, and any overpayment made to the provider are recovered, the patient will be rewarded half of the overcharge, up to \$400 per year. Any payments to participants under this program are considered as taxable income.

EXHIBIT A

(continued)

HEALTHLINE

Healthline is a program comprised of precertification requirements under the following situations: a hospital or skilled nursing facility stay; certain elective surgeries (which may also require a second opinion); certain outpatient procedures and treatments; and arranging for home health care or private duty nursing. The penalties for failure to certify medically necessary treatment are as follows: failure to precertify a hospital stay, \$400; failure to precertify required inpatient/outpatient surgery or treatment, or to obtain a second surgical opinion when requested, \$200; failure to precertify private duty nursing, home health care, or a long stay in a skilled nursing facility, \$400. The precertification penalty is not a covered expense under SBS.

EXHIBIT B

**BENEFIT SUMMARY FOR RETIREES
(CURRENT PLAN DESIGN)**

DEDUCTIBLE

\$100/\$300 per family

CO-INSURANCE PLAN PAYS

Plan pays 80% of covered medical expenses.

LIFE-TIME MAXIMUM

\$1,000,000

PRE-EXISTING CONDITIONS

None

TRAVEL

One way transportation subject to medical necessity and pre-authorization by carrier.

ALCOHOL/DRUG ABUSE

Plan pays 90% of these expenses with a limit of \$7,000 outpatient services over a two year period.

MENTAL & NERVOUS DISORDERS

Plan pays \$15 per visit with certain limitations.

PRESCRIPTION DRUGS

The plan pays 100% for generic prescriptions, 80% for brand name prescriptions.

EXHIBIT C

SUPPLEMENTAL BENEFIT SYSTEM I & II:

SBS OPTION I

Pays an additional 10% for medical expenses covered under the group plan

Pays 100% for routine physical exams, newborn care for 72 hours after birth, and immunizations

Pays rehabilitative care (100% inpatient for 60 days and 80% outpatient)

Pays 80% for convalescent care

Increases lifetime maximum of the group plan to \$1,000,000

SBS OPTION II

\$200 deductible; 20% copay, no stop loss

Covers physicians' and hospital services, prescription drugs

Does not cover dental, vision, or audio services

Substance abuse paid at 80%; maximum benefit: \$7,000 in a consecutive two year period

Mental and Nervous disorders paid at 50% after deductible; \$1,000 per year maximum

Lifetime Maximum \$250,000

Maximum of \$1,000 paid during the first 12 months for a pre-existing condition

EXHIBIT D

STATE OF ALASKA
CLAIM EXPERIENCE BY TYPE OF CARE
ACTIVE EMPLOYEE GROUP
PERCENT CHANGE IN BENEFITS PAYABLE
PLAN YEARS 1987 TO 1988

INPATIENT

Hospital Room and Board	+14.57%
Hospital Ancillary	+12.65
Surgery	+ 7.33
Assistant Surgery/Anesthesia	- 1.31
Medical	- 0.95
Total Inpatient	+11.12

	<u>Benefits Payable</u>	<u>Number of Admissions</u>	<u>Average Charge Per Admission</u>
Mental and Nervous	27.34 %	7.3 %	13.57 %
Substance Abuse	-1.31	-7.2	4.63
Total	17.61	1.8	9.52

OUTPATIENT

Facilities	72.22%
Ancillary	22.97
Surgery	11.42
Assistant Surgery/Anesthesia	7.89
X-Ray Laboratory	15.69
Pharmacy	20.84
Chiropractic	6.55
Mental & Nervous/Substance Abuse	8.69
Medical	12.76
Other Outpatient	3.17
Total Outpatient	14.57
Inpatient and Outpatient	12.95%

STATE OF ALASKA
 CLAIM EXPERIENCE BY TYPE OF CARE
 AETNA PLAN - ACTIVE EMPLOYEE GROUP
 INPATIENT
 JULY 1987 - JUNE 1988

	<u>Submitted Expenses</u>	<u>Percent of Inpatient Benefits Payable</u>	<u>Benefits Payable</u>	<u>Percent of Total Benefits Payable</u>
Hospital Room & Board (1)	\$ 7,150,077	34.14%	\$ 6,924,519	14.33%
Hospital Ancillary (1)	8,908,267	42.56	8,632,865	17.86
Surgery	2,545,441	12.09	2,452,408	5.07
Assistant Surgery/Anesthesia	893,074	4.25	862,986	1.79
Medical	<u>1,670,981</u>	<u>6.96</u>	<u>1,412,664</u>	<u>2.92</u>
Total Inpatient	\$21,167,750	100.00%	\$20,285,442	41.97%

INPATIENT UTILIZATION & COSTS
 MENTAL, NERVOUS & SUBSTANCE DISORDERS

	<u>Submitted Expenses</u>	<u>Benefits Payable</u>	<u>Percent of Inpatient Benefits Payable</u>	<u>Percent of Total Benefits Payable</u>
Mental & Nervous	\$2,256,381	\$2,149,458	10.60%	4.99%
Substance Abuse	1,141,111	1,105,049	5.45	2.56
Total	\$3,397,492	\$3,254,507	16.05%	7.55%

	<u>Number of Admissions</u>	<u>Average Charge Per Admission</u>
Mental & Nervous	205	11,007
Substance Abuse	125	9,129

STATE OF ALASKA
CLAIM EXPERIENCE BY TYPE OF CARE
AETNA PLAN - ACTIVE EMPLOYEE GROUP
OUTPATIENT
JULY 1987 - JUNE 1988

	<u>Submitted Expenses</u>	<u>Percent of Outpatient Benefits Payable</u>	<u>Benefits Payable</u>	<u>Percent of Total Benefits Payable</u>
Facilities	\$ 138,379	0.50%	\$ 114,829	0.27%
Ancillary	4,663,209	18.99	4,336,695	10.06
Surgery	2,706,760	10.90	2,488,070	5.77
Assistant Surgery/Anesthesia	502,031	2.15	490,155	1.14
X-Ray Laboratory	4,038,233	15.33	3,500,042	8.12
Pharmacy	2,770,557	10.38	2,370,830	5.50
Chiropractic	2,562,027	9.92	2,264,807	5.25
Mental & Nervous/ Substance Abuse	1,918,380	4.62	1,054,022	2.44
Medical	6,100,745	20.28	4,631,079	10.74
Other Outpatient	<u>1,765,977</u>	<u>6.93</u>	<u>1,582,487</u>	<u>3.67</u>
Total Outpatient	\$27,166,748	100.00%	\$22,833,016	-
Total Inpatient	<u>21,167,750</u>		<u>20,285,442</u>	--
TOTAL	\$48,334,498		\$48,118,458	52.96%

STATE OF ALASKA
 RANGE OF EXPENSE REPORT
 FAMILY BENEFITS PAYABLE ⁽¹⁾
 IN EXCESS OF \$10,000
 AETNA PLAN - ACTIVE EMPLOYEE GROUP
 JANUARY 1987 TO JUNE 1989

RANGE OF EXPENSE	NUMBER OF FAMILIES		
	<u>1/89 - 6/89 ⁽²⁾</u>	<u>1/88 - 12/88</u>	<u>1/87 - 12/87</u>
\$10,000 - \$20,000	321	727	719
\$20,000 - \$35,000	93	207	184
\$35,000 - \$50,000	32	59	59
\$50,000 - \$100,000	22	69	42
\$100,000 - \$150,000	6	23	21
\$150,000 +	2	6	3

(1) Benefits Payable is defined as regular benefits payable by the plan after plan provisions, i.e., deductible and coinsurance, but before coordination of benefits.

(2) First six months of experience.

STATE OF ALASKA
 INPATIENT CONFINEMENTS IN EXCESS OF \$50,000
 AETNA PLAN - ACTIVE EMPLOYEE GROUP
 JULY 1987 TO JUNE 1988

<u>Claimant Relation</u>	<u>Claimant Age</u>	<u>Submitted Expenses</u>	<u>Benefits Payable</u>	<u>Diagnosis</u>	<u>MDC</u>
Male EE	39	\$248,194	\$241,442	Aneurysm of Carotid Artery	5
Male EE	47	122,647	113,303	Full-Thickness Skin Loss	22
Male EE	48	118,894	111,284	Intermediate Coronary Syndrome	5
Wife	51	111,447	100,775	Subarachnoid Hemorrhage	1
Male EE	45	102,405	96,918	Intercranial Hemorrhage	1
Daughter	19	101,048	83,035	Intracranial Injury	24
Daughter	0	93,963	92,748	Anomalies of Pulmonary Valve	5
Male EE	45	87,387	85,042	Unspecified Intracranial Hemorrhage	1
Wife	36	82,368	79,193	Gastric Hemorrhage	6
Daughter	19	82,221	83,047	Intracranial Injury	24
Husband	58	78,694	78,604	Respiratory Failure	4
Husband	53	76,664	80,623	Rehabilitation Procedure	23
Male EE	57	76,636	56,191	Rehabilitation Procedure	23
Male EE	35	75,326	65,796	Fracture of Rib	4
Female EE	33	74,602	75,087	Complication of Prosthetic Devise	21
Daughter	18	71,211	71,134	Neurotic Depression	19
Husband	35	70,609	61,076	Fracture of Rib	4
Daughter	0	70,192	70,044	Twin, Mate Liveborn	15
Female EE	39	66,937	60,656	Meningeal Hemorrhage	1
Female EE	54	65,120	65,833	Chronic Lymphoid Leukemia	17
Son	14	65,047	62,564	Adjustment Reaction	19
Wife	49	62,690	53,152	Atrioventricular Excitation	5
Daughter	0	60,966	61,153	Single Liveborn	15
Daughter	10	59,250	58,334	Injury to Pancreas Multiple Sites	7

Daughter	0	57,260	57,360	Pre-Term Infants	15
Wife	34	56,054	50,298	Affective Psychoses	19
Male EE	51	54,987	48,171	Chronic Ischemic Heart Disease	5
Female EE	68	52,835	47,388	Aortic Aneurysm	5
Male EE	52	52,023	49,289	Primary Cardiomyopathies	10

EE = Employee

STATE OF ALASKA
TOP 20 INPATIENT FACILITIES
RANKED BY SUBMITTED EXPENSES
JULY 1987 - JUNE 1988

<u>PROVIDERS</u>	<u>LOCATION</u>	<u>SUBMITTED EXPENSE</u>	<u>PAYABLE</u>
Providence Hospital	Anchorage	\$ 3,639,459	\$ 3,581,886
Bartlett Memorial Hospital	Juneau	1,640,884	1,163,827
Humana Hospital	Anchorage	1,443,001	1,430,857
Charter North Hospital	Anchorage	1,173,099	1,156,146
Fairbanks Memorial Hosp	Fairbanks	1,156,136	1,141,414
University Hospital	Seattle	380,689	363,694
North Star Hospital	Anchorage	379,365	377,489
Swedish Hospital Med Ctr	Seattle	360,136	357,443
Virginia Mason Hospital	Seattle	322,128	329,363
Valley Hospital Assoc	Palmer	227,113	225,947
Ketchikan General Hosp	Ketchikan	225,688	222,906
Children's Hosp & Med Ctr	Seattle	219,524	206,157
Devereaux Foundation	Philadelphia	180,063	179,886
Lakeside Recovery Ctr	Alaska	153,922	150,216
Central Peninsula Gen	Soldotna	146,520	144,816
Schick Shadil Hosp	Seattle	136,967	135,076
New England Deaconess Hosp	Boston	91,194	90,844
Sitka Community Hosp	Sitka	84,432	81,759
Camelback Hospital	Phoenix	66,312	68,239
Delpelchin Children's Ctr	Houston	65,209	64,639

STATE OF ALASKA
TOP 20 INPATIENT FACILITIES
RANKED BY SUBMITTED EXPENSES
JULY 1988 - JUNE 1989

<u>PROVIDERS</u>	<u>LOCATION</u>	<u>SUBMITTED EXPENSE</u>	<u>PAYABLE</u>
Providence Hospital	Anchorage	\$ 3,922,951	\$ 3,905,752
Humana Hospital	Anchorage	2,046,073	2,027,433
Charter North Hospital	Anchorage	1,750,962	1,738,634
Bartlett Memorial Hospital	Juneau	1,591,269	1,567,946
Fairbanks Memorial Hosp	Fairbanks	1,265,681	1,250,062
University Hospital	Seattle	490,297	488,952
Swedish Hospital Med Ctr	Seattle	403,408	402,032
North Star Hospital	Anchorage	389,835	383,121
Valley Hospital Assoc	Palmer	311,450	310,050
Virginia Mason Hospital	Seattle	284,520	281,137
Children's Hosp & Med Ctr	Seattle	274,601	274,294
Charter Medical Corp	Provo	215,590	212,576
JFK Medical Ctr	Edison	199,501	199,760
Ketchikan General Hosp	Ketchikan	192,688	189,126
Hartwyck at Oak Tree	Edison	178,336	141,470
Lakeside Recovery Ctr	Alaska	172,794	168,316
Central Peninsula General	Soldotna	164,519	162,664
University Medical Ctr	Tucson	155,431	147,581
Sitka Community Hosp	Sitka	120,347	118,060
Manor West Hosp	Los Angeles	101,387	100,386

**STATE OF ALASKA
TOP 20 OUTPATIENT FACILITIES
RANKED BY SUBMITTED EXPENSES
1987**

<u>PROVIDERS</u>	<u>PROVIDER TYPE*</u>	<u>LOCATION</u>	<u>SUBMITTED EXPENSE</u>
Providence Hospital	HS	Anchorage	\$ 1,595,624
Bartlett Memorial Hospital	HS	Juneau	1,183,900
Humana Hospital	HS	Anchorage	817,321
Fairbanks Memorial Hospital	HS	Fairbanks	720,431
Sitka Community Hospital	HS	Sitka	360,314
Valley Hospital Association	HS	Palmer	273,070
Ketchikan General Hospital	HS	Ketchikan	242,990
University Hospital	HS	Seattle	195,675
Central Peninsula Hospital	HS	Soldotna	172,127
Swedish Hospital Med Ctr	HS	Seattle	137,355
Virginia Mason Hospital	HS	Seattle	125,654
Bartlett Memorial Hospital	HS	Juneau	122,282
Norton Sound Regional Hosp	HS	Nome	104,308
Kodiak Island Hospital	HS	Kodiak	93,749
Petersburg General Hospital	HS	Petersburg	83,890
South Peninsula Hospital	HS	Homer	71,797
Valdez Community Hospital	HS	Valdez	61,298
Lakeside Recovery Center	AT	Bothell	60,581
Cordova Community Hosp	HS	Cordova	59,566
Seward General Hospital	HS	Seward	57,226

* HS - Hospital

* AT - Alcoholism Treatment Facility

STATE OF ALASKA
TOP 20 OUTPATIENT FACILITIES
RANKED BY SUBMITTED EXPENSES
1988

<u>PROVIDERS</u>	<u>PROVIDER TYPE*</u>	<u>LOCATION</u>	<u>SUBMITTED EXPENSE</u>
Providence Hospital	HS	Anchorage	\$1,657,284
Bartlett Memorial Hospital	HS	Juneau	1,450,677
Fairbanks Memorial Hospital	HS	Fairbanks	1,011,416
Humana Hospital	HS	Anchorage	966,929
Our Lady of Comp Care Ctr	CF	Anchorage	512,832
Sitka Community Hospital	HS	Sitka	435,684
Valley Hospital Association	HS	Palmer	356,429
Ketchikan General Hospital	HS	Ketchikan	253,381
University Hospital	HS	Seattle	243,503
Virginia Mason Hospital	HS	Juneau	223,973
Central Peninsula Hospital	HS	Soldotna	201,414
Norton Sound Regional Hosp	HS	Nome	186,407
Swedish Hospital Med Ctr	HS	Seattle	177,489
Petersburg General Hospital	HS	Petersburg	93,861
Alaska Treatment Ctr	OT	Anchorage	86,854
South Peninsula Hospital	HS	Homer	74,815
Valdez Community Hospital	HS	Valdez	59,352
Charter North Hosp	HS	Anchorage	56,258
Seward General Hospital	HS	Seward	53,574
Kodiak Island Hospital	HS	Kodiak	45,456

- * HS - Hospital
- * CF - Convalescent Facility
- * OT - Other

STATE OF ALASKA
TOP 20 OUTPATIENT FACILITIES
RANKED BY SUBMITTED EXPENSES
1989

<u>PROVIDERS</u>	<u>PROVIDER TYPE*</u>	<u>LOCATION</u>	<u>SUBMITTED EXPENSE</u>
Bartlett Memorial Hospital	HS	Juneau	\$ 1,060,108
Providence Hospital.	HS	Anchorage	975,393
Fairbanks Memorial Hospital	HS	Fairbanks	585,295
Humana Hospital	HS	Anchorage	484,297
Valley Hospital Association	HS	Palmer	206,937
Sitka Community Hospital	HS	Sitka	129,984
Ketchikan General Hospital	HS	Ketchikan	115,751
Central Peninsula Hospital	HS	Soldotna	106,197
University Hospital	HS	Seattle	95,728
Norton Sound Regional Hosp	HS	Nome	91,526
Virginia Mason Hospital	HS	Seattle	74,348
Swedish Hospital Med Ctr	HS	Seattle	68,668
Kodiak Island Hospital	HS	Kodiak	51,329
Search Mt. Edgecombe Hosp	HS	Sitka	50,793
Petersburg General Hospital	HS	Petersburg	48,814
South Peninsula Hospital	HS	Homer	37,694
Seward General Hospital	HS	Seward	34,003
Our Lady of Comp Care Ctr	CF	Anchorage	31,230
Valdez Community Hospital	HS	Valdez	26,983
Deaconess Medical Ctr	HS	Spokane	26,259

* HS - Hospital

EXHIBIT E
HEALTH BENEFIT PLAN
FUNDING ARRANGEMENTS

	<u>Fully Insured</u>	<u>Premium Delay</u>	<u>Retrospective Premium</u>	<u>Minimum Premium</u>	<u>Minimum Premium Reserve Less</u>	<u>Self-Funded w/Stop-Loss</u>	<u>Fully Self-Funded</u>
Claim Fluctuation Margin	Paid To Carrier	Paid To Carrier	State Retains	State Retains	State Retains	State Retains	State Retains
Incurred But Not Report Reserve	Paid To Carrier	Paid To Carrier	Paid To Carrier	Paid To Carrier	State Retains	State Retains	State Retains
Claim Liability	Carrier	Carrier	Carrier	State Up To Deposit Liability ⁽¹⁾	State Up To Deposit Liability ⁽²⁾	State ⁽³⁾	State
Expenses	Paid To Carrier	Paid To Carrier	Paid To Carrier	Paid To Carrier	Paid To Carrier	State Retains	State Retains
Who Pays Claims	Carrier	Carrier	Carrier	Carrier	Carrier	Claims Administrator	Claims Administrator
Grace Period	31 Days	90 Days	31 Days	31 Days	31 Days	N/A	N/A

(1,2) - Carrier assumes liability for benefit payments which exceeds policyholder's limit.

(3) - State assumes liability up to stop-loss (reinsurance) point.

7/11/90

This refers to (1)
(1a)

STATE OF ALASKA

ACTIVE EMPLOYEES' HEALTH PLAN

UTILIZATION REPORTS

FIRST QUARTER 1990



**STATE OF ALASKA
ACTIVE EMPLOYEES' HEALTH PLAN
UTILIZATION REPORTS
FIRST QUARTER 1990**

- I. Intent of Report**
- II. Period Reported**
- III. Cost Savings Indicators**
- IV. Estimated Cost Savings**
- V. Encouraging Trends**
- VI. Next Reporting Period**

I. Intent of Reports

A. Track cost savings and other changes due to plan design modifications put in place December 1, 1989:

- 1. Healthline**
- 2. Inpatient Precertification and Review**
- 3. Outpatient Precertification**
- 4. Managed Second Opinion**
- 5. Onsite Concurrent Review**
- 6. Healthy Beginnings**
- 7. Participating Pharmacy Drug Plan**
- 8. Mail Service Drug**
- 9. Out-of-pocket Maximum Increased**
- 10. Chiropractic Care Maximum**
- 11. Deductible Carry-over**
- 12. Modification to Benefits After \$50,000
Lifetime Maximum is Reached.**
- 13. Co-ordination of Benefits Modifications**
- 14. Vision Service Plan**
- 15. Skilled Nursing Facility Care**

16. Dental

- deductible added
- coinsurance change
- maximum increased

17. Transportation

18. Third Party Liability Recovery

19. Dependent Eligibility

B. Identify Other Areas of Potential Cost Savings

STATE OF ALASKA

SUMMARY OF BENEFIT CHANGES

HEALTHLINE UTILIZATION MANAGEMENT

A family of programs designed to promote cost-effective utilization of inpatient and outpatient medical services and informed healthcare consumer behavior through direct interaction with providers and through consumer counseling and advocacy.

HOSPITAL, SKILLED NURSING FACILITY, HOME HEALTHCARE AND PRIVATE-DUTY NURSING CARE REVIEW

Proposed confinements or care are reviewed to assess medical necessity, to determine appropriateness of level of care, and to determine length of inpatient stays.

OUTPATIENT PRECERTIFICATION

Sixteen outpatient diagnostic tests and procedures require precertification through Healthline in order to determine medical necessity.

MANAGED SECOND OPINION

Certain elective procedures and treatments (selection based on high frequency of use, high cost and indications of substantial inappropriate use) are reviewed for medical necessity.

ONSITE CONCURRENT REVIEW

The program is designed to assure that medically necessary care is provided in an efficient manner. A registered nurse visits hospitalized patients daily in the Providence and Humana Hospitals in Anchorage and reviews the patient's hospital chart. Based on her daily update of the patient's condition, the nurse negotiates for alternative care modes and venues with the attending physician and can identify individual case management necessity at an early state.

HEALTHY BEGINNINGS

Healthy Beginnings is a prenatal program design to reduce employer costs associated with the birth of premature or low birth weight infants. Covered employees or their dependents are encouraged to call Healthy Beginnings for risk assessment and appropriate intervention activity.

PARTICIPATING PHARMACY DRUG PLAN

State of Alaska family members pay \$5.00 for non-generic drugs; generic prescriptions are provided at no cost to employees.

If participating pharmacists are used no filing of claims is necessary and Aetna will pay the pharmacy directly.

MAIL SERVICE DRUG PROGRAM

Brand-name drugs require a \$2.00 payment per prescription; there is no cost for generic drugs.

INCREASE IN OUT OF POCKET LIMIT

The per-person calendar stop loss limit increased from \$1,950 to \$3,950; accordingly, the individual out-of-pocket limit for 90% coinsurance items will be \$395 (not including the deductible).

CHIROPRACTIC CARE LIMITATION

Benefits for chiropractic services for spinal subluxation (whether rendered by a chiropractor, physician, osteopath, etc.) are subject to a \$750 calendar year maximum per person. The intent of this limitation has been clarified such that it is now more accurately described as a "spinal disorder limitation"; the \$750 benefit limit only applies to office visits, exams, consultations and regional manipulations.

DEDUCTIBLE CARRYOVER

Expenses incurred in the last three months of a calendar year, and applied toward that year's deductible will no longer also count toward the succeeding calendar year deductible obligation.

BENEFITS AFTER \$50,000 PAID CLAIMS

Individuals exceeding \$50,000 in lifetime paid benefits are required to satisfy the annual deductible; in addition, benefits in excess of \$50,000 are paid at 90% (rather than 100%) up to the \$3,950 out of pocket limit.

COORDINATION OF BENEFITS

The State of Alaska plan, when it is the secondary plan under order of payment rules, will pay the difference between what the primary plan has paid and the regular benefits that would be paid under the State plan in the absence of any coordination of benefits; this "maintenance of benefits" approach no longer automatically provides 100% COB benefits.

PARTICIPATING VISION CARE PROGRAM (VSP)

A network of vision care providers and facilities offer services and supplies at negotiated prices.

Employees are responsible for minimal deductible payments for exams and standard eyewear purchases; the additional cost of special options or cosmetic/fashion features is paid in full by the employee.

SKILLED NURSING FACILITY CARE

Benefits for Skilled Nursing/Extended Care Facility confinement expenses for room and board and other medical services and supplies will be paid at 100% after the deductible; this benefit is only available if the skilled nursing facility confinement is a medically necessary alternative to an acute care inpatient hospital stay.

DENTAL EXPENSE COVERAGE

A \$25 annual deductible (with a \$75 family limit) applies to all restorative and other expenses not preventative in nature; the deductible is waived for expenses in connection with oral exams, x-rays, fluoride applications and cleanings.

Dental expenses such as extractions, periodontics, root canal treatment, oral surgery, and fillings are paid at 85% after the deductible rather than 90%.

Benefits for full mouth x-rays will be provided only once per calendar year per person.

Calendar year maximum increased from \$1,000 to \$1,500.

TRANSPORTATION BENEFITS

A per diem benefit to defray the cost of meals and lodging for employees or dependents who must travel to have preoperative testing and surgery is available. In addition, travel benefits includes coverage for transportation costs to the extent inpatient treatment in another location is less expensive than costs at the location nearest the employee.

THIRD PARTY RECOVERY

There is a requirement that individuals reimburse Aetna on behalf of the plan to the extent a covered family member recovers medical expenses from a third party wrongdoer or another insurance company. This provision prevents double recovery of expenses resulting from injuries due to an act or omission of a third party.

DEPENDENT ELIGIBILITY

Dependent children between the ages of 19 and 23 must be attending school regularly in order to be covered under the plan, provided they are also unmarried and chiefly dependent of the employee for support.

II. Period Reported

A. Period Covered

1. Incurred Claims Up to March 1990

- Includes incurred claims from last quarter 1989

2. Claims Paid During First Quarter 1990

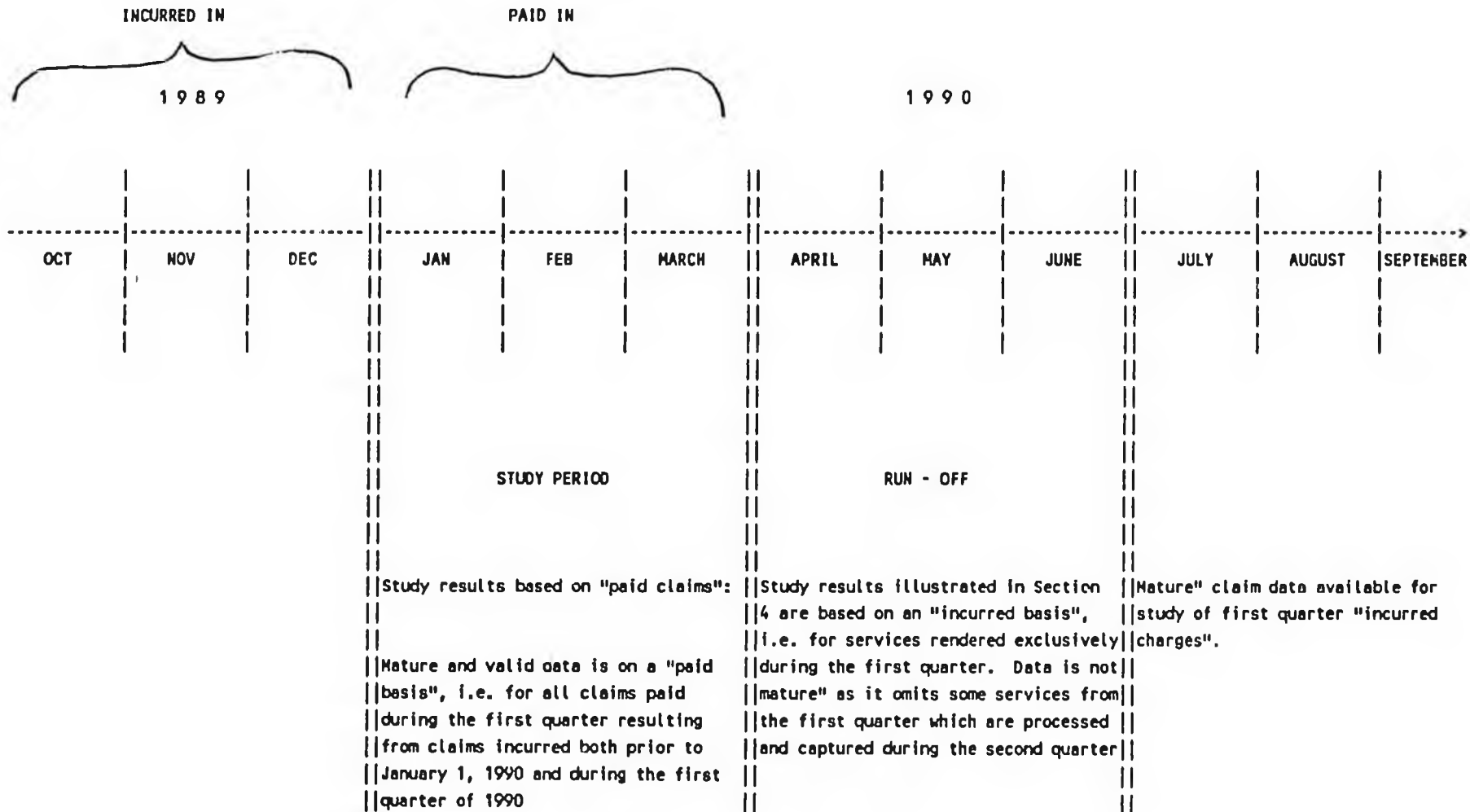
B. Incurred vs. Paid

C. Incurred Basis

- Immature data
- Incurred after January 1, paid through April 30

D. One Quarter is Insufficient For Hard Projections

CLAIM TIMELINE



III. Cost Savings Indicators

A. Healthy Beginnings

- **49 of 64 identified as increased risk**
- **3 required physician referral**
- **Average age 32**

B. Per Diem Travel Reimbursement

- **5 cases**

C. Third Party Liability Recovery

- **38 cases identified**

IV. Estimated Cost Savings Indicators

A. Inpatient Precertification

B. Onsite Concurrent Review

C. Procedure Precertification

D. Outpatient Precertification

E. Managed Second Opinion

F. Home Health Care Precertification

G. Skilled Nursing Facilities

339 approved
317 declined
22 met

90 approved (initial)
10% declined (initial)
no further appeals in
admission.

217 approved
201 approved

124 approved
71 approved

V. Encouraging Trends

A. Overall Costs Were Down for First Quarter 1990

- Total expenses decreased by 8.1% or \$84 per employee on paid basis
- Total expenses decreased by 9.7% or \$83 per employee on incurred basis

B. Utilization Decreased

- Admission and Patient days (per 1,000 employees)
- Average length of stay unchanged
- Inpatient surgical procedures decreased 3.5%
- Outpatient surgical procedures increased, but not as high as Aetna book of business (18.4%)

C. No change in distribution of services

A. See Item / Blue paragraph.
B. See Item / Blue paragraph.

VI. Next Reporting Period

- A. Paid Data With Sufficient Run-off Will Correspond With Plan Design Changes**
- B. Will be Able to Track Actual Dollars Saved**
 - 1. Overall plan savings**
 - 2. Chiropractic services**
 - 3. Vision care claims**
 - 4. Prescription drug costs**
 - 5. Dental**
- C. Data Will be Complete**

1a

**STATE OF ALASKA
HEALTHCARE EXPERIENCE
FIRST QUARTER 1990**

**PREPARED BY:
CUSTOMER CONSULTING SERVICES
AETNA LIFE INSURANCE COMPANY
JUNE, 1990**

STATE OF ALASKA
HEALTHCARE EXPERIENCE
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Other Plan Design Changes 6

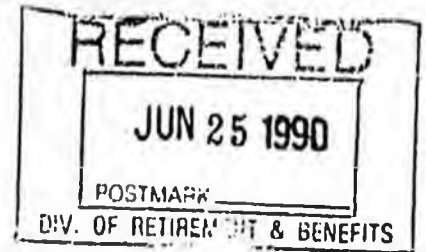
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Appendix 8

- o **Glossaries**
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- Procedure Precertification Activity** 51
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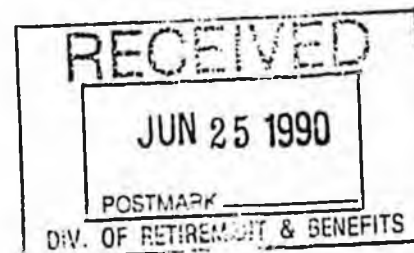
EXECUTIVE SUMMARY



The following evaluation provides an initial view of the emerging trends of the State of Alaska's medical and dental healthcare experience through a comparison of first quarter 1989 and first quarter 1990 claim data. All data is presented for the active employee group only. The primary focus of this evaluation is to determine the impact of changes made to the State's health plan in December 1989 and January 1990.

- o The State of Alaska's average healthcare benefit per employee for the combined experience of the indemnity plan, Vision Service Plan, Prescription Card Service (PAR Drug) and Mail Order Drug Program (MEDCO) was \$951 in the first quarter of 1990 compared to \$1,035 in the first quarter of 1989. This represents an 8.1% decrease in cost to the plan.
- o The estimated savings to the State of Alaska for the first quarter 1990 was \$892,772 or \$68 per employee. The \$68 savings is the difference between the \$1,035 per employee benefit in the first quarter 1989 and the sum of the \$951 benefit in first quarter 1990 plus \$16 program cost.
- o The precertification and other utilization management programs helped to significantly reduce hospital use patterns. Inpatient bed days per 1000 employees declined from 424 days per 1000 employees in the first quarter 1989 to 342 bed days per 1000 employees in the first quarter 1990.
- o Hospital benefits paid for treatment of psychiatric disorders and for the treatment of substance abuse disorders declined by 53% and 54%, respectively.
- o The cost to the plan for reimbursement of chiropractic expenses was reduced by 36.6% from \$509,205 (\$41 per employee) in the first quarter 1989 to \$335,760 or \$26 per employee in first quarter 1990.
- o Dental benefits paid by the State of Alaska's healthcare plan decreased from \$167 per employee in the first quarter of 1989 to \$148 per employee during the comparable period in 1990.

- o The Utilization Management program activity indicates 715 requests for precertification of a hospital stay. Eighty of the requested stays (11%) were averted. 6,753 bed days were requested of which 2,903 (43%) were averted. The onsite nurse in Anchorage reviewed 93 cases and 356 bed days were averted.
- o There were 482 procedures requested through the procedure protocol program; Outpatient Precertification and Managed Second Opinion. Thirty five (7.3%) of these requests were not certified.
- o There are 64 active participants in the Healthy Beginnings Program (high risk pregnancy). Seventy five percent (49/64) of the participants were classified at increased risk for delivery of low birth weight infants and are receiving proactive intervention services from the Healthline nursing staff.



INTRODUCTION & OVERVIEW

In order to help control their escalating health care costs, the State of Alaska implemented a series of Utilization Management Programs and plan design changes on December 1, 1989 and on January 1, 1990. These changes to the health benefit program the State provides to its approximately 13,000 active employees are described in Exhibit A of this section.

The State of Alaska requested that Aetna's Customer Consulting Services Department develop the necessary management reports to monitor program activity and to perform an assessment of the effects of plan design and program changes from utilization and expense perspectives.

Our principal objective in the first phase of this project was to develop management reports which reflect both program activity and results. Initial reports of preliminary overall results are presented in Section 4. Reports on Utilization Management program activity and plan changes are located in Sections 5 and 6.

Exhibit A briefly describes the changes that the State made to its health care program. The majority of these plan design changes and new utilization management programs became effective on December 1, 1989. The optimal method of assessing the impact of these changes calls for the use of patient service data which occurred exclusively on or after January 1, 1990, i.e. for claims "incurred" during 1990 only. Additional discussion on this issue is found in Section 3 - Methodology. Unfortunately, during this initial review, it is not possible to rely exclusively on this approach.

For this initial study, we elected to use the total set of data available, which represents all claim services paid for during the first quarter of 1990 and to compare it to the analogous "paid claim" data which occurred during the first quarter of 1989.

As the program matures, we will make an assessment of the health care program changes using only data for patient services incurred on and after January 1, 1990.

Our recommendations for future reporting and evaluation of the impact of changes on the State of Alaska's healthcare costs is found in Section 7 - Summary.

STATE OF ALASKA

SUMMARY OF BENEFIT CHANGES

HEALTHLINE UTILIZATION MANAGEMENT

A family of programs designed to promote cost-effective utilization of inpatient and outpatient medical services and informed healthcare consumer behavior through direct interaction with providers and through consumer counseling and advocacy.

HOSPITAL, SKILLED NURSING FACILITY, HOME HEALTHCARE AND PRIVATE-DUTY NURSING CARE REVIEW

Proposed confinements or care are reviewed to assess medical necessity, to determine appropriateness of level of care, and to determine length of inpatient stays.

OUTPATIENT PRECERTIFICATION

Sixteen outpatient diagnostic tests and procedures require precertification through Healthline in order to determine medical necessity.

MANAGED SECOND OPINION

Certain elective procedures and treatments (selection based on high frequency of use, high cost and indications of substantial inappropriate use) are reviewed for medical necessity.

ONSITE CONCURRENT REVIEW

The program is designed to assure that medically necessary care is provided in an efficient manner. A registered nurse visits hospitalized patients daily in the Providence and Humana Hospitals in Anchorage and reviews the patient's hospital chart. Based on her daily update of the patient's condition, the nurse negotiates for alternative care modes and venues with the attending physician and can identify individual case management necessity at an early state.

HEALTHY BEGINNINGS

Healthy Beginnings is a prenatal program design to reduce employer costs associated with the birth of premature or low birth weight infants. Covered employees or their dependents are encouraged to call Healthy Beginnings for risk assessment and appropriate intervention activity.

PARTICIPATING PHARMACY DRUG PLAN

State of Alaska family members pay \$5.00 for non-generic drugs; generic prescriptions are provided at no cost to employees.

If participating pharmacists are used no filing of claims is necessary and Aetna will pay the pharmacy directly.

MAIL SERVICE DRUG PROGRAM

Brand-name drugs require a \$2.00 payment per prescription; there is no cost for generic drugs.

INCREASE IN OUT OF POCKET LIMIT

The per-person calendar stop loss limit increased from \$1,950 to \$3,950; accordingly, the individual out-of-pocket limit for 90% coinsurance items will be \$395 (not including the deductible).

CHIROPRACTIC CARE LIMITATION

Benefits for chiropractic services for spinal subluxation (whether rendered by a chiropractor, physician, osteopath, etc.) are subject to a \$750 calendar year maximum per person. The intent of this limitation has been clarified such that it is now more accurately described as a "spinal disorder limitation"; the \$750 benefit limit only applies to office visits, exams, consultations and regional manipulations.

DEDUCTIBLE CARRYOVER

Expenses incurred in the last three months of a calendar year, and applied toward that year's deductible will no longer also count toward the succeeding calendar year deductible obligation.

BENEFITS AFTER \$50,000 PAID CLAIMS

Individuals exceeding \$50,000 in lifetime paid benefits are required to satisfy the annual deductible; in addition, benefits in excess of \$50,000 are paid at 90% (rather than 100%) up to the \$3,950 out of pocket limit.

COORDINATION OF BENEFITS

The State of Alaska plan, when it is the secondary plan under order of payment rules, will pay the difference between what the primary plan has paid and the regular benefits that would be paid under the State plan in the absence of any coordination of benefits; this "maintenance of benefits" approach no longer automatically provides 100% COB benefits.

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Employees are responsible for minimal deductible payments for exams and standard eyewear purchases; the additional cost of special options or cosmetic/fashion features is paid in full by the employee.

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Benefits for Skilled Nursing/Extended Care Facility confinement expenses for room and board and other medical services and supplies will be paid at 100% after the deductible; this benefit is only available if the skilled nursing facility confinement is a medically necessary alternative to an acute care inpatient hospital stay.

DENTAL EXPENSE COVERAGE

A \$25 annual deductible (with a \$75 family limit) applies to all restorative and other expenses not preventative in nature; the deductible is waived for expenses in connection with oral exams, x-rays, fluoride applications and cleanings.

Dental expenses such as extractions, periodontics, root canal treatment, oral surgery, and fillings are paid at 85% after the deductible rather than 90%.

Benefits for full mouth x-rays will be provided only once per calendar year per person.

Calendar year maximum increased from \$1,000 to \$1,500.

TRANSPORTATION BENEFITS

A per diem benefit to defray the cost of meals and lodging for employees or dependents who must travel to have preoperative testing and surgery is available. In addition, travel benefits includes coverage for transportation costs to the extent inpatient treatment in another location is less expensive than costs at the location nearest the employee.

THIRD PARTY RECOVERY

There is a requirement that individuals reimburse Aetna on behalf of the plan to the extent a covered family member recovers medical expenses from a third party wrongdoer or another insurance company. This provision prevents double recovery of expenses resulting from injuries due to an act or omission of a third party.

DEPENDENT ELIGIBILITY

Dependent children between the ages of 19 and 23 must be attending school regularly in order to be covered under the plan, provided they are also unmarried and chiefly dependent of the employee for support.

METHODOLOGY

The purpose of this study is to assess the impact of all utilization management programs and plan design changes on the State of Alaska's healthcare experience. In an effort to review activity both before and after benefit changes, we have primarily focussed on data for the first quarter 1989 and the first quarter 1990 to facilitate the comparison of comparable time periods and pre- and post- results.

SOURCE OF DATA

Data analyzed in this study was extracted from AECCLAIMS, Aetna's computerized claim payment system which manages all of Aetna's policyholder's claim submissions. All healthcare expense and utilization statistics were obtained from AEACCESS Basic Reports and Aetna's AEACCESS database which contains information on all inpatient and outpatient claims processed for the State of Alaska within the past 27 months.

Data on Utilization Management program activity was obtained from Aetna's system resources and records maintained in our Seattle claim office. Additionally, information was provided by Aetna's PAR drug information system, MEDCO, and the Vision Service Plan.

EXPOSURE DATA

To enable accurate comparisons of utilization and expenses between comparable time periods, as well as between the State's and Aetna's normative data, factors have been developed to express utilization in relative terms, such as admissions per 1000 employees, bed days per 1000 employees and expenses per employee.

Numbers of employees used in the calculation of "per 1000 employees" and "per employee" factors were supplied by the State of Alaska. The employee counts provided are as follows:

	<u>JANUARY</u>	<u>FEBRUARY</u>	<u>MARCH</u>	<u>QUARTER AVERAGE</u>
1ST QTR 89'	12,558	12,702	12,936	12,732
1ST QTR 90'	13,017	13,107	13,264	129

SOURCE: State of Alaska

NORMATIVE DATA

The normative data presented for comparison with the State's experience is based on Aetna's Book of Business and so represents average results for employers with all types of health benefit plans.

In all cases the normative values represent the midpoint of an expected range and should not be considered absolute values. Because the State's employee demographics differ from Aetna's Book of Business, these norms are general benchmarks of average results for groups with a wide range of demographics characteristics.

PAID VERSUS INCURRED DATA

For this first evaluation, data represents all claim services paid for during the first quarter of 1990 compared to paid claim data for first quarter 1989, however as previously indicated, this is not the optimal method of assessing the impact of program and plan changes.

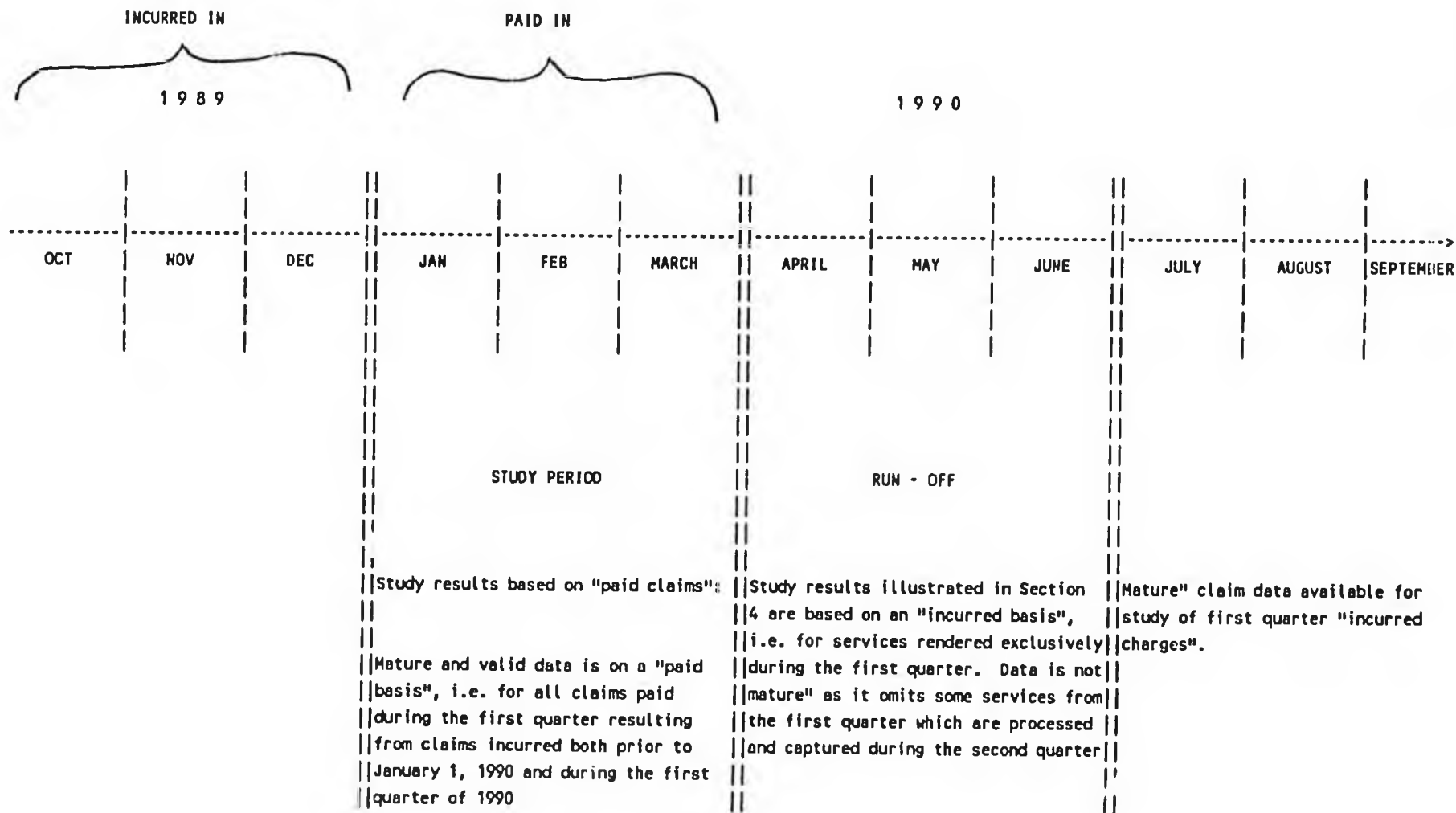
In many instances, the time span between the date that patient service occurs and the date that the claim payment is made and recorded in our database is three months. As a result, the total set of data available at the time of this assessment is inclusive of:

- o Patient services rendered prior to January 1st, e.g. December, November and October of 1989, or even earlier, but paid in the first quarter of 1990, and
- o omissions for some patient services rendered in January, February and March of 1990 but not yet paid and recorded in the first quarter of 1990.

We were able to isolate data exclusively for claims "incurred" during the first quarter of 1990 and TABLES 4-6 in Section 4 have reflected the results. For the reason noted above, however, it would be inappropriate to consider this data valid as it omits some services which occurred during the later portion of the first quarter, i.e., this data is "immature".

The exhibit on the following page provides a visual display of the impact of claim lag and the value of allowing sufficient time to elapse before the most credible "view" of claim data is undertaken.

CLAIM TIMELINE



Study results based on "paid claims":

Mature and valid data is on a "paid basis", i.e. for all claims paid during the first quarter resulting from claims incurred both prior to January 1, 1990 and during the first quarter of 1990

Study results illustrated in Section 4 are based on an "incurred basis", i.e. for services rendered exclusively during the first quarter. Data is not "mature" as it omits some services from the first quarter which are processed and captured during the second quarter

"Mature" claim data available for study of first quarter "incurred charges".

FINDINGS

EXPENSE

Total healthcare benefits in the first quarter 1990 including the Vision Service plan, the Mail Order Drug program and the Prescription Card program are \$951 per employee. The average benefits paid per employee during the first quarter 1989 were \$1,035. This represents an 8.1% reduction in per employee claim costs over time. (TABLE 1)

The first quarter 1990 estimated savings to the State when the cost of Healthline programs is considered is \$892,772.

CLAIM COSTS PER EMPLOYEE

1ST QUARTER 1990

Aetna Indemnity	\$906
Vision Service Plan	28
Prescription Drug Card	14
Mail Order Drug	3
Utilization Management Programs	<u>16</u>
	\$967

1ST OTR 1989

1ST OTR 1990

\$1,035 - \$967 = \$68

\$68 X 13,129 employees = \$892,772 1st Qtr. Savings

NOTE: 1989 dollars are not adjusted for inflation.

Employees paid \$171 or 12.7% in cost sharing plan features, i.e., deductible and coinsurance during the first quarter 1989. In the first quarter of 1990 employees paid \$157 or 13.3% of covered charges. Employees paid 8.2% fewer actual dollars, however the portion of covered charges being shared by employees increased.

Although the deductible paid in the first quarter per employee decreased from \$91 to \$87, this probably results from the influence of 1989 incurred services included in paid results. When viewed on an incurred basis (TABLE 4), i.e., paid claims for services incurred in the first quarter 1990, the deductible portion remained

the same as 1989 levels. We expect therefore, that when 1990 incurred data is more complete, the positive effects of the plan changes which eliminated the deductible carry-over provision and the deductible waiver on large claims will become more evident.

The amount of savings due to coordination of benefits decreased from \$144 to \$118 per employee (-18.1%). These are our findings, however, because the savings from the Maintenance of Benefits approach is captured in the NOT COVERED expenses as opposed to COB savings this will involve further study in order to give a better idea of the impact of Maintenance of Benefits.

UTILIZATION

The precertification and other inpatient utilization management programs, i.e. On-Site nurse and Managed Second Opinion, have positively impacted hospital use patterns. The programs have helped to reduce the level of hospital inpatient utilization (patient days per 1000 employees) from 424 days in the first quarter 1989 to 342 days in the first quarter 1990 (-19.3%). (TABLE 2.) This 19.3% decrease was better than Aetna's book of business. The 10% decrease in bed days experienced by Aetna perhaps also reflects the influence of our healthline programs. In addition hospital admission rates per 1000 employees for the State's population declined 18.7%.

This reduction in inpatient hospital services is a major factor in the overall decrease in both submitted charges and healthcare benefits paid by the State of Alaska.

The average length of stay remained virtually unchanged. Utilization Management programs work to avert unnecessary short stay admissions, therefore this result is not unexpected. This is however only a single quarter comparison and results may fluctuate over time.

TYPES OF CARE

HOSPITAL

When benefits paid by the State's health plan are examined by specific types of care (TABLE 3) it is clear that inpatient experience had the greatest impact on the reduction in overall benefits paid. Total inpatient costs per employee decreased 14.9% from \$477 per employee in 1989 to \$406 per employee in 1990. Outpatient benefits decreased only 5.4%, from \$483 to \$457.

When per employee benefits for hospital services, i.e., room and board and ancillaries are examined separately from all other inpatient benefits, the decrease is even more dramatic. Psychiatric benefits declined 53% and substance abuse confinement costs are down 54%. The number of inpatient days associated with psychiatric and substance abuse treatment will be examined when paid claim data more closely reflect services incurred after program implementation.

INPATIENT HOSPITAL BENEFITS PER EMPLOYEE

	1ST QTR 89	1ST QTR 90	%CHANGE
Hospital Room & Board and Ancillaries (Medical/Surgical)	\$288	\$262	-9%
Hospital Room & Board and Ancillaries (Psychiatric)	\$60	\$28	-53%
Hospital Room & Board and Ancillaries (Substance Abuse)	\$28	\$13	-54%
TOTAL	----- \$376	----- \$303	----- -19%

CHIROPRACTIC

Benefits paid for chiropractic services also showed a significant decrease (-36.6%). \$509,205 or \$41 per employee was paid in the first quarter of 1989 compared to 335,760 or \$26 per employee from January 1 through March 31, 1990.

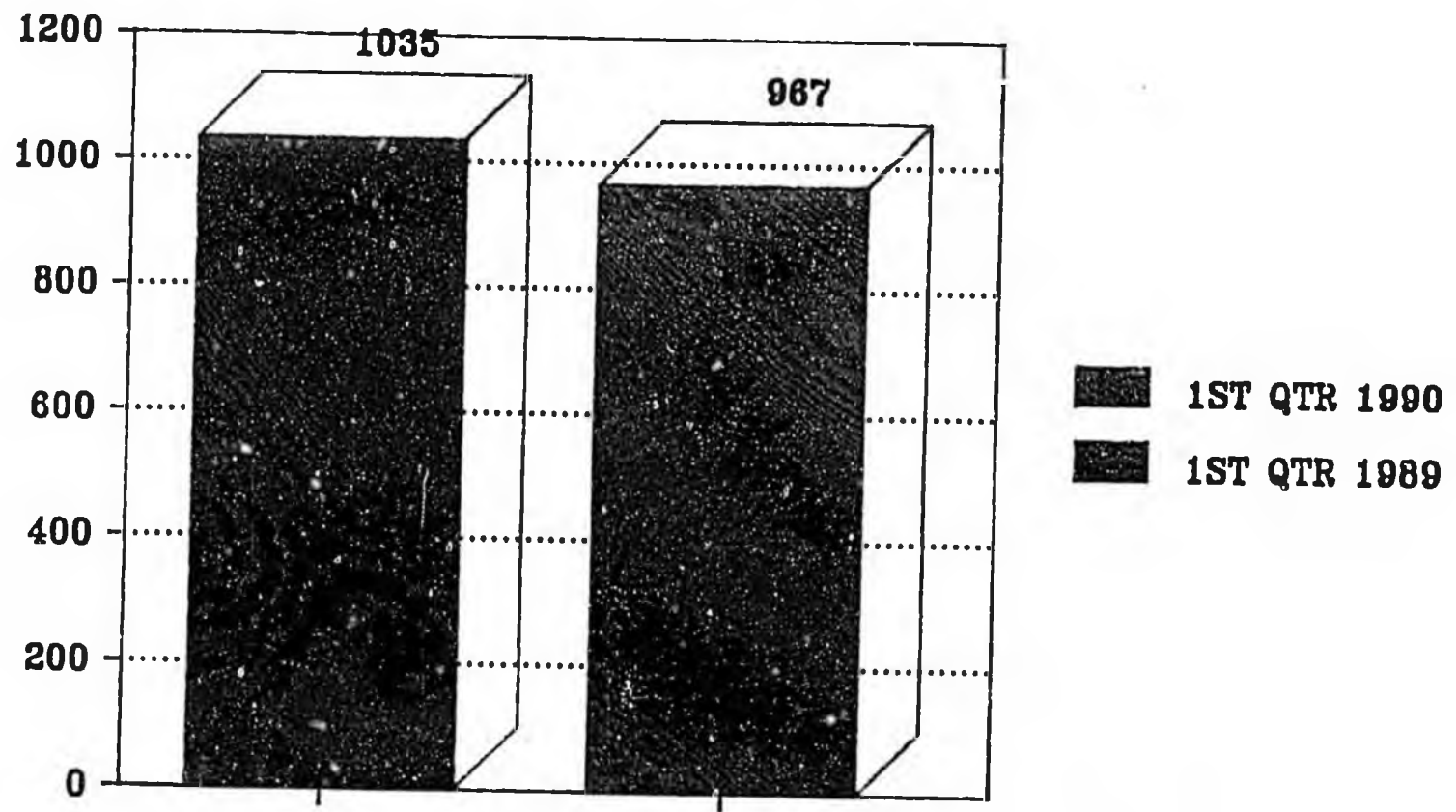
This result was impacted by the \$750 calendar year maximum added to the plan. A more detailed view of the chiropractic experience for the first quarter of 1990 is provided on TABLE 18 in Section 6.

DENTAL

The plan also experienced a decrease (-11.4%) in dental benefits over time, from \$167 per employee in first quarter 1989 to \$148 per employee in first quarter 1990.

The addition of a \$25 deductible, the change from 90% coinsurance to 85% for certain services, limitation on full-mouth x-rays and the required pre-treatment authorizations all contributed to this result. The impact of the increase in the annual maximum will become more evident as the year progresses.

STATE OF ALASKA HEALTHCARE PLAN SAVINGS PER EMPLOYEE



$$\$88 \times 13129 = \$892,772$$

(SAVINGS PER EE) (EMPLOYEES) (1ST QTR 90 SAVINGS)

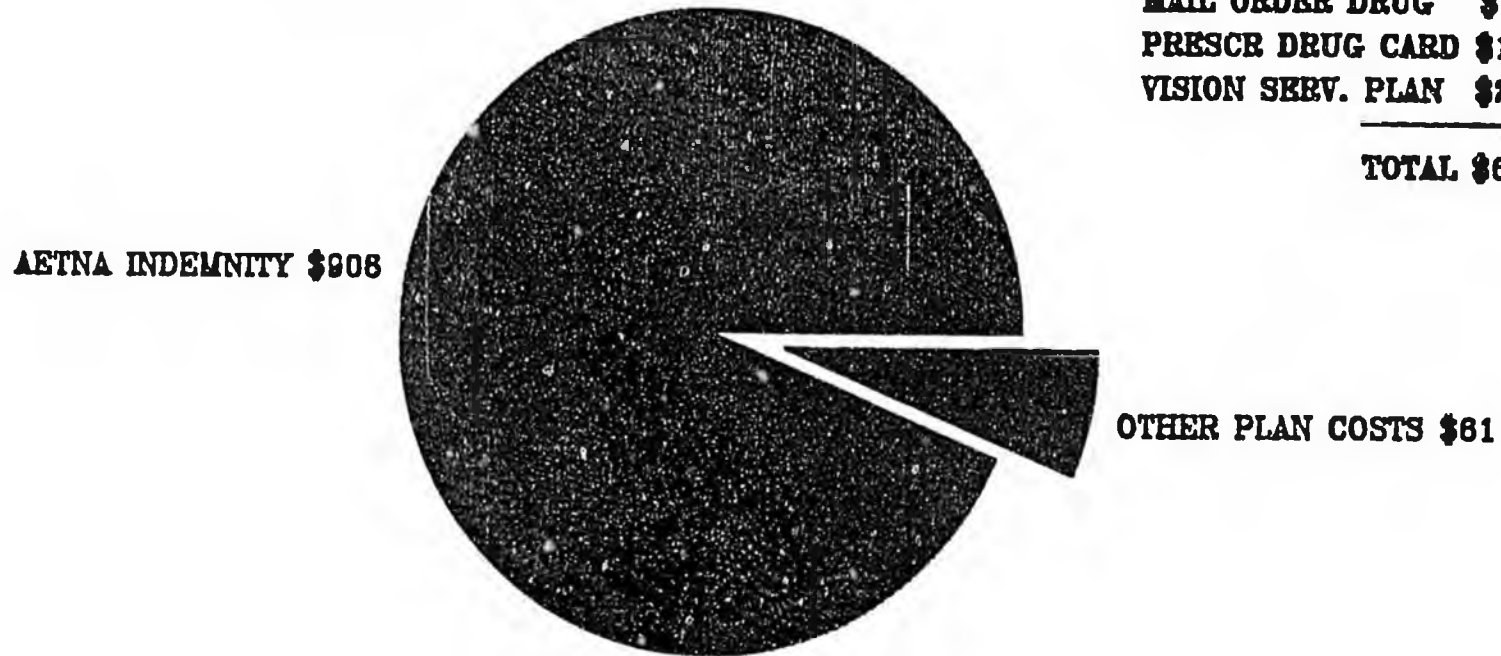
STATE OF ALASKA

TOTAL HEALTHCARE CLAIM COSTS PER EMPLOYEE

OTHER PLAN COSTS:

UTILIZATION MGT. \$16
MAIL ORDER DRUG \$ 3
PRESCR DRUG CARD \$14
VISION SERV. PLAN \$28

TOTAL \$61



1ST QUARTER 1990

STATE OF ALASKA
SUMMARY OF EXPENSE
PAID CLAIMS
ACTIVE EMPLOYEE GROUP

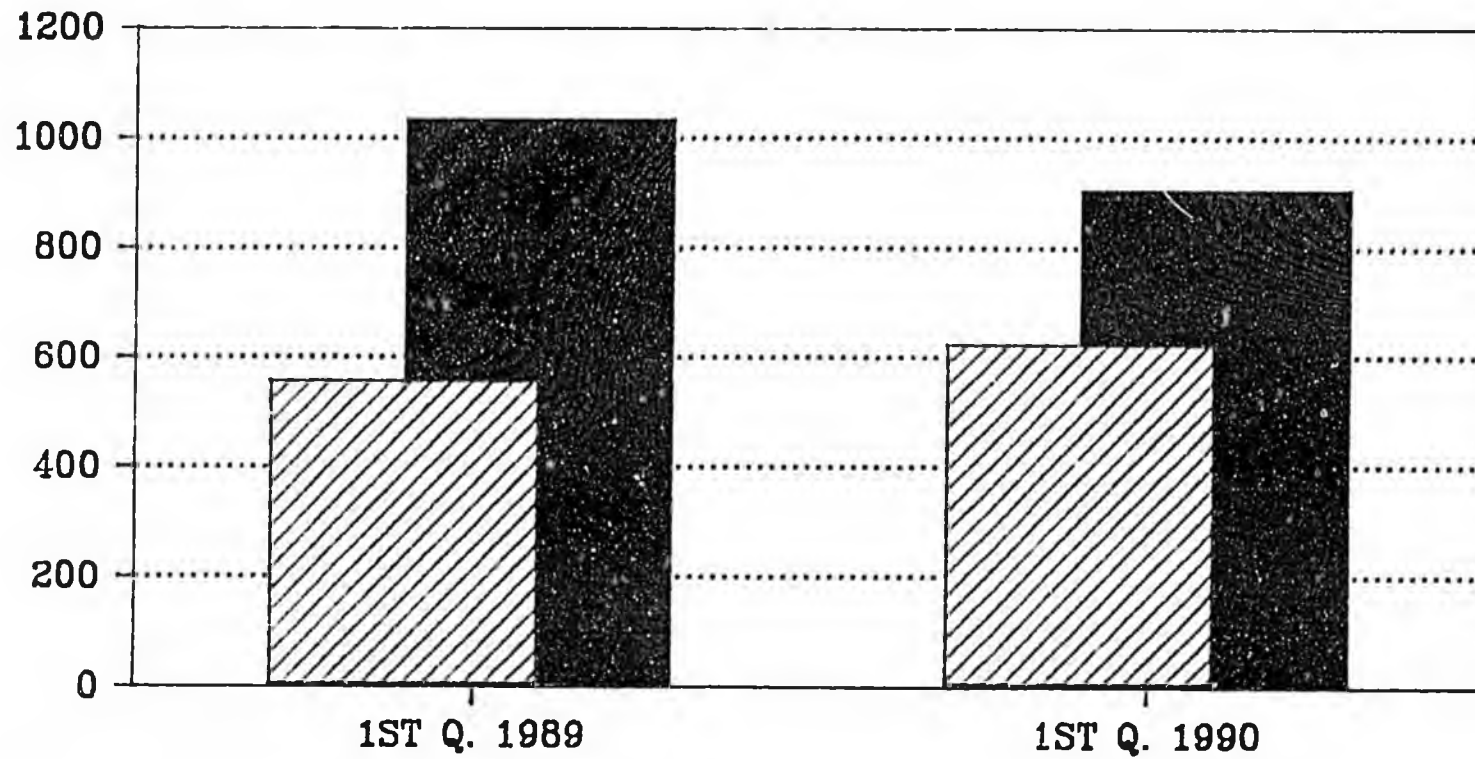
TABLE 1

KEY INDICATORS (PER EMPLOYEE)	STATE OF ALASKA				AETNA BOOK OF BUSINESS		
	1ST QTR. 1989	1ST QTR. 1990	% CHANGE	DOLLAR CHANGE	1989	1990	% CHANGE
GROSS SUBMITTED EXPENSES	\$1,575	\$1,457	-7.5	-\$118	\$881	\$958	8.7
CLAIM ADMINISTRATION SAVINGS & OTHER NOT COVERED	\$225	\$275	22.2	\$50	\$172	\$195	13.4
EXPENSES COVERED	\$1,350	\$1,182	-12.5	-\$168	\$709	\$763	7.6
EXPENSES PAID BY EMPLOYEES							
DEDUCTIBLE	\$91	\$85	-6.6	-\$6	\$55	\$60	9.1
CO-PAY	\$80	\$72	-10.0	-\$8	\$69	\$75	8.7
TOTAL COST SHARING	\$171	\$157	-8.2	-\$14	\$124	\$135	8.9
COST SHARING AS % OF COVERED	12.7%	13.3%	4.7	-	17.5%	17.7%	1.0
COB	\$144	\$118	-18.1	-\$26	\$22	\$21	-4.5%
EXPENSES PAID BY PLAN	\$1,035	\$906	-12.5	-\$129	\$556	\$599	7.7
TOTAL EXPENSES PAID BY PLAN INCLUDING VSP, PAR, MEDCO	\$1,035	\$951	-8.1	-\$84			
NUMBER OF EMPLOYEES:	1ST QUARTER	1989	12,732				
	1ST QUARTER	1990	13,129				

STATE OF ALASKA

NET PAID PER EMPLOYEE

TREND



 AETNA B.O.B.

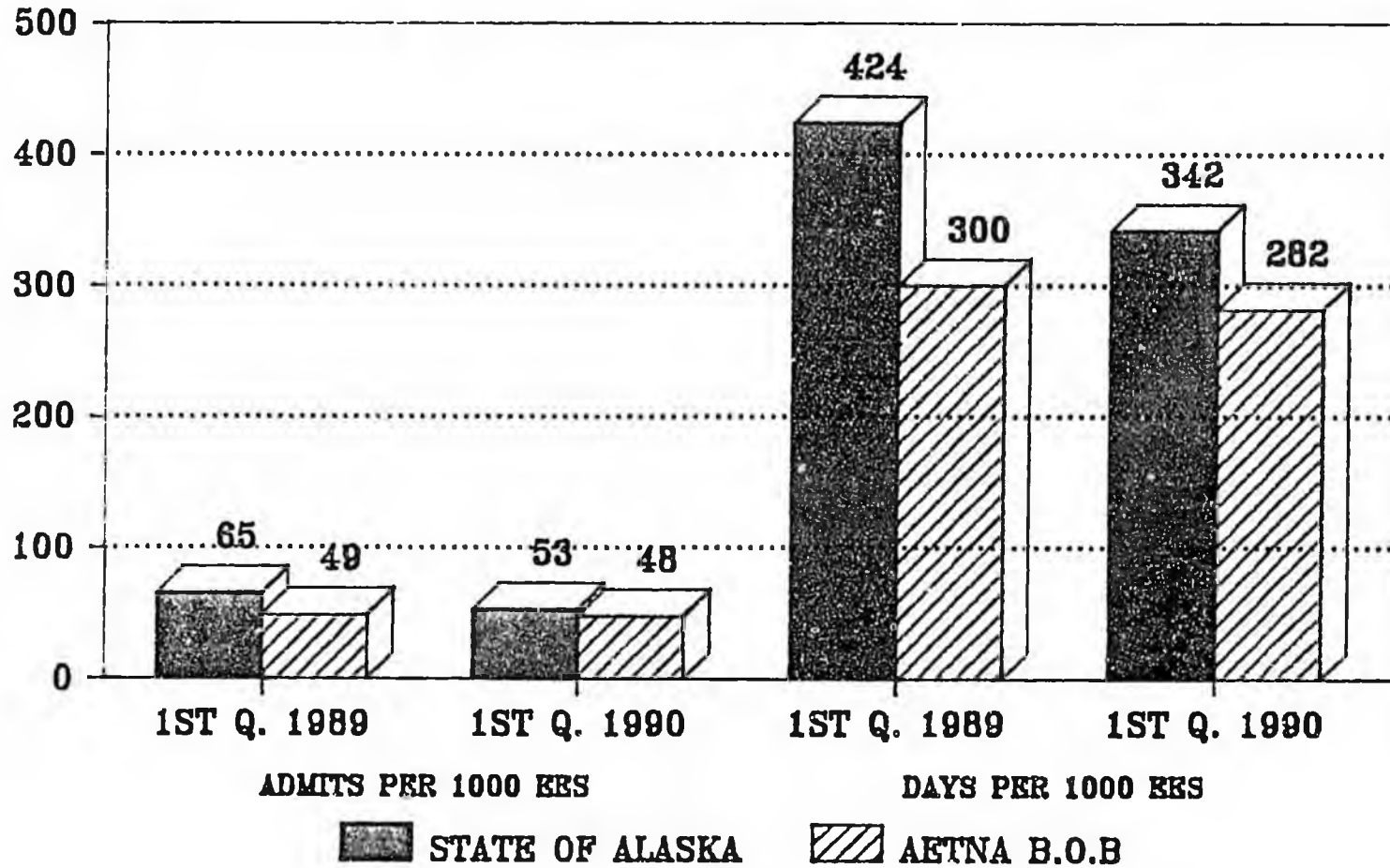
 STATE OF ALASKA

STATE OF ALASKA
SUMMARY OF HEALTHCARE UTILIZATION
PAID CLAIMS
ACTIVE EMPLOYEE GROUP

TABLE 2

	STATE OF ALASKA			AETNA BOOK OF BUSINESS		
	1ST QUARTER 1989	1ST QUARTER 1990	% CHANGE	1ST QUARTER 1989	1ST QUARTER 1990	% CHANGE
HEALTHCARE UTILIZATION PER 1000 EE'S						
ADMISSIONS	65	53	-18.7	49	46	-6.1
PATIENT DAYS	424	342	-19.3	300	270	-10.0
AVERAGE LENGTH OF STAY	6.5	6.5	-0.7	6.1	5.9	-3.3
SURGICAL PROCEDURES						
INPATIENT	50	48	-5.5	41	39	-4.9
OUTPATIENT	255	264	3.4	163	166	18.4
% INPATIENT	16.5%	15.3%	-7.3	20.1%	18.9%	-6.0
NUMBER OF EE'S	12,732	13,129	3.1			

STATE OF ALASKA HEALTHCARE UTILIZATION



STATE OF ALASKA
 BENEFITS PAYABLE BY TYPE OF CARE PER EMPLOYEE
 PAID CLAIMS
 ACTIVE EMPLOYEE GROUP

TABLE 3

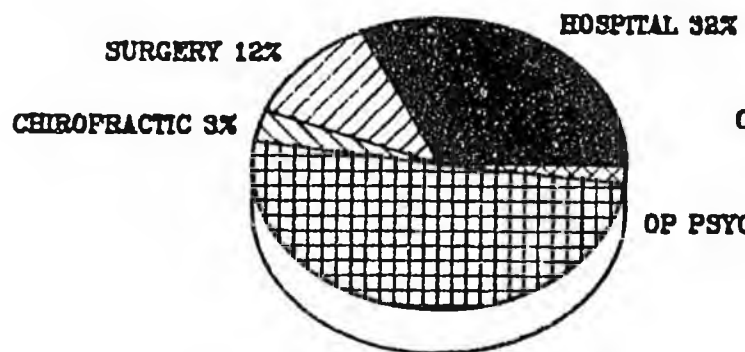
INPATIENT	1ST QTR 1989	1ST QTR 1990	% CHANGE
HOSPITAL ROOM & BOARD (EXCL. PSYCH/SUB ABUSE)	\$103	\$97	-5.8%
HOSPITAL ANCILLARIES	\$185	\$165	-10.8%
ROOM & BOARD - PSYCHIATRIC	\$43	\$21	-51.2%
ANCILLARIES	\$17	\$7	-58.8%
ROOM & BOARD - SUBSTANCE ABUSE	\$9	\$7	-22.2%
ANCILLARIES	\$19	\$6	-68.4%
SURGERY (ASST. SURG/ANES)	\$76	\$76	0.0%
MEDICAL	\$26	\$28	7.7%
TOTAL INPATIENT	\$477	\$406	-14.9%
OUTPATIENT			
ANCILLARIES (INCL. FACILITIES)	\$109	\$118	8.3%
SURGERY (ASST. SURG/ANES)	\$66	\$65	-1.5%
MEDICAL	\$89	\$81	-9.0%
X-RAY & LABORATORY	\$76	\$73	-3.9%
PRESCRIPTION DRUG *	\$52	\$39	
CHIROPRACTIC	\$41	\$26	-36.6%
PSYCHIATRIC/SUBSTANCE ABUSE	\$23	\$19	-17.4%
OTHER OUTPATIENT	\$29	\$35	20.7%
TOTAL OUTPATIENT	\$483	\$457	-5.4%
TOTAL MEDICAL	\$960	\$863	-10.1%
DENTAL			
PREVENTATIVE	\$56	\$56	0.0%
RESTORATIVE	\$62	\$53	-14.5%
OTHER	\$50	\$38	
TOTAL DENTAL	\$167	\$148	-11.4%
VISION (1990 EXPERIENCE INCLUDES AETNA RUN-OFF)	\$48	\$6	
TOTAL	\$1,176	\$1,017 **	-13.5%
TOTAL INCLUDING VSP, PAR, & MEDCO	\$1,176	\$1,062	-9.7%
NUMBER OF EE'S	12,732	13,129	3.1%

* DOES NOT INCLUDE PAR OR MAIL ORDER DRUG EXPERIENCE. SEE REPORT IN SECTION 6 FOR TOTAL EXPERIENCE.

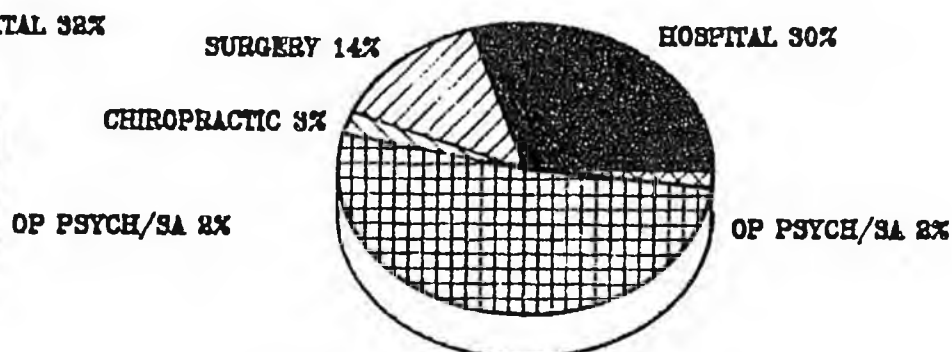
** BENEFITS PAYABLE IS DEFINED AS THE REGULAR BENEFITS PAYABLE BY PLAN AFTER DEDUCTIBLE & COINSURANCE BUT BEFORE COORDINATION OF BENEFITS.

STATE OF ALASKA

DISTRIBUTION OF BENEFITS



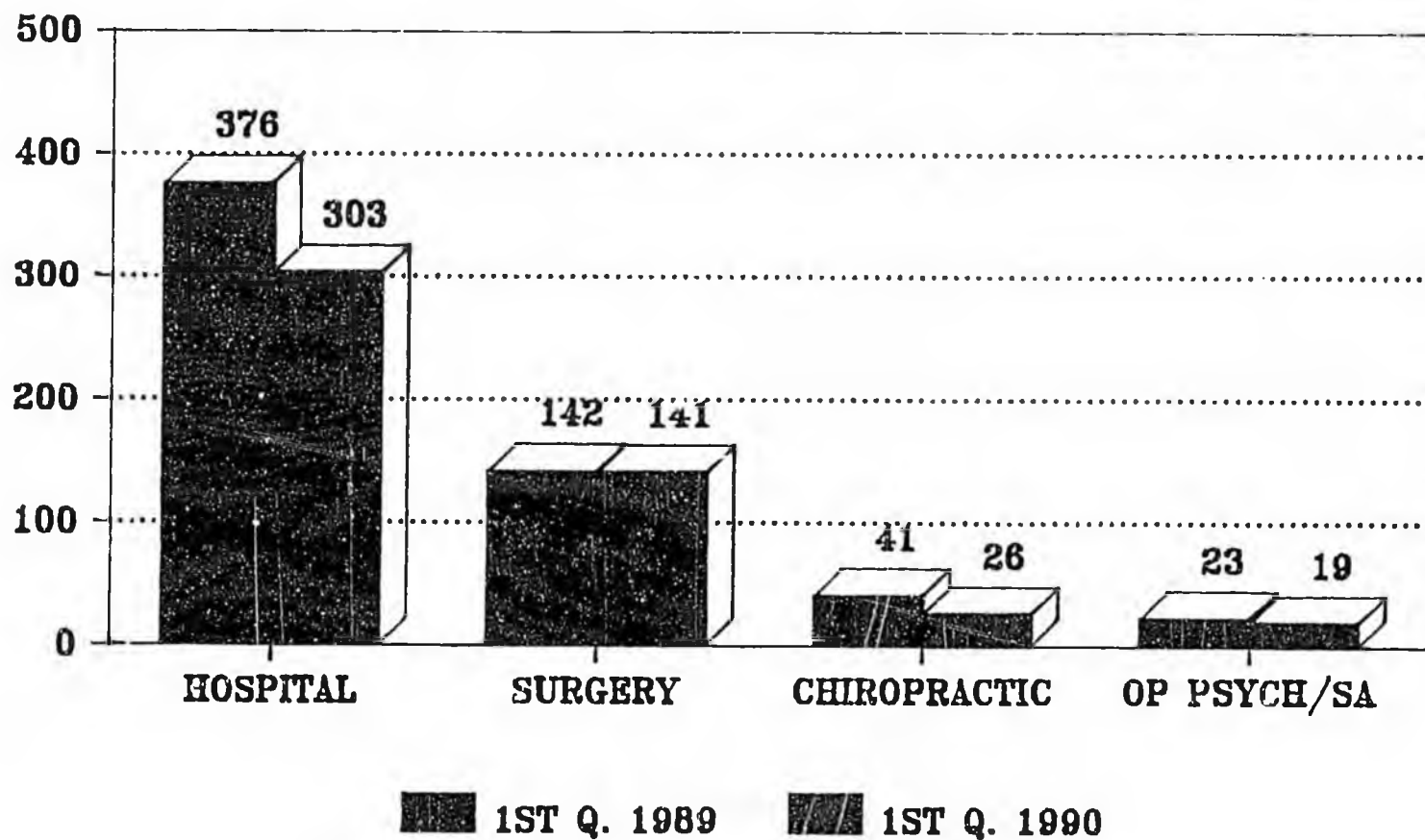
1ST Q. 1989



1ST Q. 1990

STATE OF ALASKA

BENEFITS PAYABLE FOR SELECTED SERVICES PER EMPLOYEE



RECEIVED
JUN 25 1990
POSTMARK _____
DIV. OF RETIREMENT & BENEFITS

The following Tables 4, 5 and 6 present data for services incurred during the first quarter 1990. While the data is incomplete due to insufficient "lag time" the trend, -14.9% in NET PAID PER EE, is interesting to note.

STATE OF ALASKA
SUMMARY OF EXPENSE
INCURRED CLAIMS
ACTIVE EMPLOYEE GROUP

TABLE 4

KEY INDICATORS (PER EMPLOYEE)	STATE OF ALASKA			DOLLAR CHANGE
	1ST QTR. 1989	1ST QTR. 1990	% CHANGE	
GROSS SUBMITTED EXPENSES	\$1,236	\$1,123	-9.1	-\$113
CLAIM ADMINISTRATION SAVINGS & OTHER NOT COVERED	\$127	\$169	33.1	\$42
EXPENSES COVERED	\$1,109	\$954	-14.0	-\$155
EXPENSES PAID BY EMPLOYEES				
DEDUCTIBLE	\$92	\$92	0	\$0
CO-PAY	\$68	\$54	-20.6	-\$14
TOTAL COST SHARING	\$160	\$146	-8.8	-\$14
COST SHARING AS % OF COVERED	14.4%	15.3%	6.3	-
COORDINATION OF BENEFITS	\$91	\$79	-13.2	-\$12
EXPENSES PAID BY PLAN	\$858	\$730	-14.9	-\$128
TOTAL EXPENSES PAID BY PLAN INCLUDING VSP, PAR, MEDCO	\$858	\$775	-9.7	-\$83
NUMBER OF EMPLOYEES:				
1ST QUARTER	1989	12,732		
1ST QUARTER	1990	13,129		

NOTE: THIS DATA IS BASED ONLY ON SERVICES INCURRED BETWEEN JANUARY AND MARCH, 1990.

STATE OF ALASKA
SUMMARY OF HEALTHCARE UTILIZATION
INCURRED CLAIMS
ACTIVE EMPLOYEE GROUP

TABLE 5

	STATE OF ALASKA			AETNA BOOK OF BUSINESS		
	1ST QUARTER 1989	1ST QUARTER 1990	% CHANGE	1ST QUARTER 1989	1ST QUARTER 1990	% CHANGE
HEALTHCARE UTILIZATION PER 1000 EE'S						
ADMISSIONS	62	28	-54.3	36	34	-6.0
PATIENT DAYS	446	123	-72.5	190	170	-10.5
AVERAGE LENGTH OF STAY	7.1	4.3	-39.8	5.3	5	-5.7
SURGICAL PROCEDURES						
INPATIENT	40	12	-70.0	5	3	-40.0
OUTPATIENT	234	133	-43.2	19	14	-26.3
% INPATIENT	14.5%	8.3%	-42.8	20.1%	18.9%	-6.0
 NUMBER OF EE'S	 12,732	 13,129	 3.1			

NOTE: THIS DATA IS BASED ONLY ON SERVICES INCURRED BETWEEN JANUARY AND MARCH, 1990

STATE OF ALASKA
 BENEFITS PAYABLE BY TYPE OF CARE PER EMPLOYEE
 (INCURRED)
 ACTIVE EMPLOYEE GROUP

TABLE 6

INPATIENT	1ST QTR 1989	1ST QTR 1990	CHANGE
HOSPITAL ROOM & BOARD (EXCL. PSYCH/SUB ABUSE)	\$84	\$80	-4.8%
HOSPITAL ANCILLARIES	\$129	\$129	0.0%
ROOM & BOARD - PSYCHIATRIC	\$41	\$22	-46.3%
ANCILLARIES	\$17	\$8	-52.9%
ROOM & BOARD - SUBSTANCE ABUSE	\$8	\$2	-75.0%
ANCILLARIES	\$12	\$2	-83.3%
SURGERY (ASST. SURG/ANES)	\$58	\$50	-13.8%
MEDICAL	\$19	\$20	5.3%
TOTAL INPATIENT	\$369	\$314	-14.9%
OUTPATIENT			
ANCILLARIES (INCL. FACILITIES)	\$88	\$97	10.2%
SURGERY (ASST. SURG/ANES)	\$56	\$49	-12.5%
MEDICAL	\$67	\$59	-11.9%
X-RAY & LABORATORY	\$63	\$59	-6.3%
PRESCRIPTION DRUG *	\$36	\$26	-27.8%
CHIROPRACTIC	\$35	\$19	-45.7%
PSYCHIATRIC/SUBSTANCE ABUSE	\$18	\$15	-16.7%
OTHER OUTPATIENT	\$21	\$24	14.3%
TOTAL OUTPATIENT	\$383	\$347	-9.4%
TOTAL MEDICAL	\$751	\$661	-12.0%
DENTAL			
PREVENTATIVE	\$51	\$52	2.0%
RESTORATIVE	\$53	\$45	-15.1%
OTHER	\$43	\$32	-25.6%
TOTAL DENTAL	\$147	\$129	-12.2%
VISION	\$45	\$0	N/A
TOTAL	\$944	\$790 **	-16.3%
NUMBER OF EE'S	12,732	13,129	3.1%

* DOES NOT INCLUDE PAR OR MAIL ORDER DRUG EXPERIENCE. SEE REPORT IN SECTION 6 FOR TOTAL EXPERIENCE

** BENEFITS PAYABLE IS DEFINED AS THE REGULAR BENEFITS PAYABLE BY PLAN AFTER DEDUCTIBLE & COINSURANCE BUT BEFORE COORDINATION OF BENEFITS

UTILIZATION MANAGEMENT ACTIVITY COMMENTS

Utilization Management activity is helping to reduce plan costs as evidenced by the following:

- o 715 inpatient precertification requests were reviewed during the first quarter of 1990 of which 11% (80/717) admissions were averted. There were 3,850 bed days certified and 2,903 bed days denied. The average length of certification was 5.9 days for all diagnoses combined.
- o 93 cases involved onsite concurrent review of which 442 days were certified and 356 days were denied.
- o Outpatient precertification/Managed Second Opinion reviews totalled 482 during first quarter 1990 with an estimated combined savings of \$193,174 due to averted procedures.
- o Of 217 Home Health Care visits requested, 201 were approved and 16 visits saved.
- o Four claimants precertified for skilled nursing facility admissions of which 134 days were requested and 71 days were approved.
- o Five people took advantage of the per diem travel benefit constituting \$323.95 dollars paid in benefits.

Following the first full six months of the precertification programs and the appropriate claim lag time, we will be reporting on paid claim activity and days actually used relative to the precertification activity during the same time period i.e., January 1990 through June 1990.

HEALTHY BEGINNINGS

There has been much interest in the Healthy Beginnings Program (High Risk Pregnancy) as shown by the 64 women who participated in the first quarter 1990.

Of note:

- o 75% (49/64) of the participants were classified at increased risk,
- o the average gestation at time of first contact was approximately 18 weeks, and
- o the average age of the participant was 32 years of age.

See individual case studies on pages 37 - 38 of this section.

Observations by Claim Management

Claim management personnel and Healthline nurses responsible for the administration of the Utilization Management programs and other plan changes made the following observations:

- o As expected the volume of phone calls by the State of Alaska employees to the Aetna claim office increased dramatically from approximately 6,000 per month in early 1989 to approximately 10,000 per month in the first quarter 1990.
- o Most employees, if they commented on the new programs at all, said that they understood the problem of escalating healthcare costs. There were, of course, some complaints about changes to the plan.
- o The most frequently expressed dissatisfaction was with the Maintenance of Benefits approach to Coordination of Benefits. Employees seem to be confused by the change and upset by the resultant benefit levels.
- o Nurses responsible for precertification report few instances of employee dissatisfaction and a diminished level of hostility on the part of the Provider community although pockets of resistance remain.

STATE OF ALASKA
HOSPITAL INPATIENT PRECERTIFICATION ACTIVITY REPORT
ACTIVE EMPLOYEE GROUP
JANUARY 1, 1990 - MARCH 31, 1990

TABLE 7

DIAGNOSTIC GROUPING	REQUESTED CONFINEMENTS		REQUESTED BED DAYS		AVERAGE LENGTH OF CERTIFICATION		HEALTHLINE *
	CERTIFIED (1)	DENIED (2)	CERTIFIED (3)	DENIED (4)	1990 (5)	1989 (6)	
MEDICAL/SURGICAL	399	57	1487	1604	3.7	0	0
MATERNITY	163	7	331	244	2.0	0	0
PSYCHIATRIC							
ADJUSTMENT-DISORDER	4	0	95	60	23.8	0	0
AFFECTIVE-BIPOLAR	1	0	26	4	26.0		
AFFECTIVE-DEPRESSED	16	0	457	50	28.6		
AFFECTIVE-OTHER	3	1	109	7	36.3	0	0
ANXIETY	0	0	0	0	0.0	0	0
BORDERLINE	0	0	0	0	0.0	0	0
CONDUCT	1	0	18	3	18.0	0	0
EATING DISORDER	0	0	0	0	0.0	0	0
MULTIPLE PERSONALITY	0	0	0	0	0.0	0	0
PERSONALITY (OTHER)	0	0	0	0	0.0	0	0
PSYCHOTIC	0	0	0	0	0.0	0	0
SCHIZOPHRENIC	2	1	23	11	11.5	0	0
SUBTOTAL - PSYCH	27	2	728	135	27.0	0	0
SUBSTANCE ABUSE							
ALCOHOL ABUSE	16	4	375	94	23.4	0	0
COCAINE	0	0	0	0	0.0	0	0
ORGANIC	8	0	127	40	15.9	0	0
SOMATOFORM	0	0	0	0	0.0	0	0
OTHER SUBSTANCE	11	1	359	70	32.6	0	0
SUBTOTAL - SUB ABUSE	35	5	861	204	24.6	0	0
OTHER PSYCH & SUBSTANCE ABUSE	15	5	443	118	29.5	0	0
TOTAL	639	76	3,850	2,305	6.0	0	0

* 1990 AETNA BOOK OF BUSINESS HEALTHLINE DATA WILL BE AVAILABLE SEPTEMBER 1990.

STATE OF ALASKA
HOSPITAL INPATIENT PRECERTIFICATION ACTIVITY REPORT
ACTIVE EMPLOYEE GROUP
JANUARY 1, 1990 - MARCH 31, 1990

TABLE 7

DIAGNOSTIC GROUPING	REQUESTED CONFINEMENTS		REQUESTED BED DAYS		AVERAGE LENGTH OF CERTIFICATION		
	CERTIFIED (1)	DENIED (2)	CERTIFIED (3)	DENIED (4)	1990 (5)	1989 (6)	HEALTHLINE * (7)
MEDICAL/SURGICAL	399	57	1487	1604	3.7	0	0
MATERNITY	163	7	331	244	2.0	0	0
PSYCHIATRIC							
ADJUSTMENT-DISORDER	4	0	95	60	23.8	0	0
AFFECTIVE-BIPOLAR	1	0	26	4	26.0		
AFFECTIVE-DEPRESSED	16	0	457	50	28.6		
AFFECTIVE-OTHER	3	1	109	7	36.3	0	0
ANXIETY	0	0	0	0	0.0	0	0
BORDERLINE	0	0	0	0	0.0	0	0
CONDUCT	1	0	18	3	18.0	0	0
EATING DISORDER	0	0	0	0	0.0	0	0
MULTIPLE PERSONALITY	0	0	0	0	0.0	0	0
PERSONALITY (OTHER)	0	0	0	0	0.0	0	0
PSYCHOTIC	0	0	0	0	0.0	0	0
SCHIZOPHRENIC	2	1	23	11	11.5	0	0
SUBTOTAL - PSYCH	27	2	728	135	27.0	0	0
SUBSTANCE ABUSE							
ALCOHOL ABUSE	16	4	375	94 (see comment)	23.4	0	0
COCAINE	0	0	0	692 (rest)	0.0	0	0
ORGANIC	8	0	127	40	15.9	0	0
SOMATOFORM	0	0	0	0	0.0	0	0
OTHER SUBSTANCE	11	1	359	70	32.6	0	0
SUBTOTAL - SUB ABUSE	35	5	861	802	24.6	0	0
OTHER PSYCH & SUBSTANCE ABUSE	15	5	443	118	29.5	0	0
TOTAL	639	76	3,850	2,903	6.0	0	0

* 1990 AETNA BOOK OF BUSINESS HEALTHLINE DATA WILL BE AVAILABLE SEPTEMBER 1990.

STATE OF ALASKA
HOSPITAL INPATIENT PRECERTIFICATION ACTIVITY REPORT
ONSITE CONCURRENT REVIEW
ACTIVE EMPLOYEE GROUP
JANUARY 1, 1990 - MARCH 31, 1990

TABLE 8

DIAGNOSTIC GROUPING	REQUESTED CONFINEMENTS		REQUESTED BED DAYS		AVERAGE LENGTH OF CERTIFICATION		HEALTHLINE (7)
	CERTIFIED (1)	DENIED (2)	CERTIFIED (1)	DENIED (2)	1990 (5)	1989 (6)	
MEDICAL/SURGICAL	74	4	379	329	5.1	0	0
MATERNITY	14	1	63	27	4.5	0	0
TOTAL	88	5	442	356	5.0	0	0

NOTE: THE DATA IN THIS TABLE IS A SUBSET OF ACTIVITY REPORTED IN TABLE 7 AND REFLECTS ACTIVITY OF THE "ONSITE" NURSE IN ANCHORAGE.

STATE OF ALASKA
 PROCEDURE PRECERTIFICATION ACTIVITY
 ACTIVE EMPLOYEE GROUP
 JANUARY 1, 1990 - MARCH 31, 1990
 PRECERTIFICATION ACTIVITY

TABLE 9

	TOTAL CASES REQUESTED	TOTAL CASES REFERRED MD	TOTAL CASES CERTIFIED	TOTAL CASES NOT CERTIFIED	PERCENTAGE NOT CERTIFIED	
					THIS PERIOD	SAME PERIOD LAST YEAR
OUTPATIENT PRECERTIFICATION	345	33	323	22	6.4%	N/A
MANAGED SECOND OPINION	137	9	124	13	9.5%	N/A
TOTAL	482	42	447	35	7.3%	

*Page 31-32
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STATE OF ALASKA
 OUTPATIENT PRECERTIFICATION PROGRAM
 ESTIMATED SAVINGS BY PROTOCOL
 ACTIVE EMPLOYEE GROUP
 JANUARY 1, 1990 - MARCH 31, 1990

TABLE 13

PROCEDURE	TOTAL REQUESTS	TOTAL CERTIFIED	TOTAL DENIED	AVERAGE CHARGE PER PROCEDURE	ESTIMATED SAVINGS
BUNIONECTOMY	13	12	1	\$4,497	\$4,497
CARP TUNNEL REL	14	13	1	\$3,312	\$3,312
COLONOSCOPY	45	39	6	\$1,312	\$7,872
CORONARY ANGIO	8	8	0	\$0	\$0
CYSTOSCOPY	25	22	3	\$2,706	\$8,118
DILATION & CURETTAGE	42	38	4	\$2,399	\$9,596
HAMMERTOES	2	2	0	\$0	\$0
ING HERNIA REP	19	19	0	\$0	\$0
KNEE ARTHRO	59	58	1	\$5,145	\$5,145
PELVIC LAP	28	28	0	\$0	\$0
STABISMUS REP	3	3	0	\$0	\$0
TYMPANOSTOMY	37	33	4	\$1,956	\$7,824
UGI ENDOSCOPY	44	42	2	\$1,174	\$2,348
TOTAL	339	317	22		\$48,712

STATE OF ALASKA
 MANAGED SECOND OPINION
 ESTIMATED SAVINGS BY PROTOCOL
 ACTIVE EMPLOYEE GROUP
 JANUARY 1, 1990 - MARCH 31, 1990

TABLE 12

PROCEDURE	TOTAL REQUESTS	TOTAL CERTIFIED	TOTAL DENIED	AVERAGE CHARGE PER PROCEDURE 1989	ESTIMATED SAVINGS
ADENOIDECTOMY	4	3	1	\$290	\$290
CABS/CABG <i>Coronary Bypass</i>	5	5	0	\$0	\$0
CATARACT	9	8	1	\$5,725	\$5,725
CORONARY ANGIO	0	0	0	\$0	\$0
HYSTERECTOMY	59	57	2	\$12,812	\$25,624
LAMINECTOMY	20	18	2	\$9,295	\$18,590
LOW BACK PAIN	12	6	6	\$15,449	\$92,694
MENISCECTOMY	0	0	0	\$0	\$0
PACEMAKER	0	0	0	\$0	\$0
PROSTATECTOMY	0	0	0	\$0	\$0
T & A <i>Tonsils & Adenoids</i>	9	9	0	\$0	\$0
TONSILLECTOMY	18	17	1	\$1,539	\$1,539
TOTAL	136	123	13		\$144,462

STATE OF ALASKA
HEALTHY BEGINNINGS ACTIVITY
ACTIVE EMPLOYEE GROUP
JANUARY 1, 1990 - MARCH 31, 1990

TABLE 14

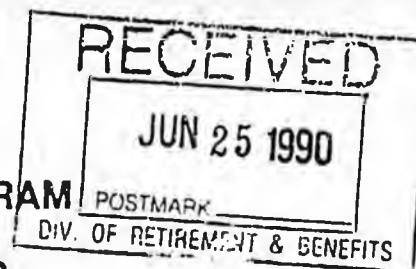
CASE NUMBER	CLAIMANT AGE	NO. WEEKS PREGNANT AT INITIAL CONTACT	RISK CLASSIFICATION	NURSING INTERVENTION (COUNT)	PHYSICIAN REFERRAL REQUIRED
1	30	17	INCREASED	4	NO
2	18	19	INCREASED	8	YES
3	43	18	INCREASED	2	NO
4	32	11	INCREASED	2	NO
5	38	23	INCREASED	3	NO
6	36	13	INCREASED	4	NO
7	28	7	INCREASED	2	NO
8	25	24	INCREASED	2	NO
9	30	26	INCREASED	2	NO
10	30	26	INCREASED	2	NO
11	26	23	INCREASED	3	NO
12	27	9	INCREASED	3	NO
13	28	9	INCREASED	2	NO
14	38	22	INCREASED	2	NO
15	37	7	INCREASED	3	NO
16	31	24	INCREASED	3	NO
17	27	23	INCREASED	2	NO
18	38	14	INCREASED	2	NO
19	33	21	INCREASED	2	NO
20	28	17	INCREASED	3	NO
21	23	23	INCREASED	2	NO
22	34	29	INCREASED	5	NO
23	33	9	INCREASED	3	YES
24	37	26	INCREASED	2	NO
25	33	24	INCREASED	3	NO
26	29	29	INCREASED	3	NO
27	35	22	INCREASED	2	NO
28	31	32	INCREASED	2	NO
29	35	18	INCREASED	3	NO
30	33	29	INCREASED	7	NO
31	35	7	INCREASED	3	NO

STATE OF ALASKA
HEALTHY BEGINNINGS ACTIVITY
ACTIVE EMPLOYEE GROUP
JANUARY 1, 1990 - MARCH 31, 1990

TABLE 14

CASE NUMBER	AGE	NO. WEEKS PREGNANT AT INITIAL CONTACT	RISK CLASSIFICATION	NURSING INTERVENTION (COUNT)	PHYSICIAN REFERRAL REQUIRED
32	30	29	INCREASED	2	NO
33	32	10	INCREASED	2	NO
34	28	22	INCREASED	2	NO
35	33	15	INCREASED	2	NO
36	36	13	INCREASED	4	NO
37	35	7	INCREASED	3	NO
38	29	10	INCREASED	2	NO
39	40	9	INCREASED	4	NO
40	26	29	INCREASED	4	NO
41	35	15	INCREASED	2	NO
42	36	18	INCREASED	2	NO
43	20	16	INCREASED	3	NO
44	37	12	INCREASED	3	NO
45	36	7	INCREASED	2	NO
46	38	17	INCREASED	3	NO
47	32	22	INCREASED	2	NO
48	33	11	INCREASED	2	NO
49	33	6	INCREASED	3	YES
50	25	18	NORMAL	3	NO
51	29	5	NORMAL	2	NO
52	29	9	NORMAL	2	NO
53	29	9	NORMAL	2	NO
54	29	24	NORMAL	2	NO
55	29	25	NORMAL	2	NO
56	25	7	NORMAL	2	NO
57	29	13	NORMAL	2	NO
58	33	27	NORMAL	2	NO
59	35	19	NORMAL	2	NO
60	32	11	NORMAL	3	NO
61	34	18	NORMAL	2	NO
62	28	26	NORMAL	3	NO
63	32	24	NORMAL	2	NO
64	24	12	NORMAL	2	NO
AVERAGE	32	18	36		

STATE OF ALASKA
HEALTHY BEGINNINGS PROGRAM
INDIVIDUAL CASE STUDIES



Case # 1

This Nome patient first called saying she couldn't afford food or vitamins. We counselled her on adequate inexpensive foods and found a source in Anchorage that she was able to send away for mail order pre-natal vitamins.

Case # 2

An eighteen-year-old financially unsupported, single, pregnant female currently living with a sibling, required assistance in locating a doctor in the area. Not aggressive in learning about prenatal and newborn care and was not able to get into a childbirth class. We have encouraged her to do as much as possible on her own and have recommended library books, etc. At thirty-four weeks gestation she called us with signs of premature labor. The attending physician told her to go to the hospital, the hospital was telling her to stay home. She called us confused and in pain. We instructed her to go to the hospital. After coaching her through several contractions her labor was stopped at the hospital and we hope for an uneventful outcome.

Case # 8

Patient with hydramnions perceives that the doctor is withholding information. There are no other practitioners in the area. The patient had numerous questions. We developed strategies to improve her communication with her doctor, i.e. ask for longer appointments, make a list of her questions, have the office nurse answer some of the questions. We have reports that the communication has improved.

Case # 30

This patient at twenty-nine weeks gestation had preterm labor which required parenteral tocolytics. We set up a Toco's uterine monitor and home care for medication administration. The patient delivered a healthy baby at full term.

Case 49

Patient with first trimester nausea and vomiting. Discussed options to hospital admission for hydration, i.e. home care, doctor's office. Patient and doctor agree, IV's given at doctor's office periodically allowing her to stay home and care for her other children. This patient also had a urinary tract infection which she refused to treat because she was worried about fetal effects. Education was provided regarding the rationale for antibiotics. She then went ahead with treatment but unfortunately not in time to prevent a miscarriage. If she gets pregnant again she will be a better patient.

STATE OF ALASKA
HOME HEALTH CARE
PRECERTIFICATION ACTIVITY
ACTIVE EMPLOYEE GROUP
JANUARY 1, 1990 - MARCH 31, 1990

TABLE 15

CASE NUMBER	CLAIMANT AGE	DIAGNOSIS	VISITS REQUESTED	VISITS APPROVED	VISITS SAVED
1	41	LYMPHOMA	1	1	0
2	49	MULTIPLE MYELOMA	5	5	0
3	53	MALIGNANT NEOPLASM OF COLON	15	13	2
4	35	MELANOMA OF SKIN	9	9	0
5	32	EARLY OR THREATENED LABOR	76	62	14
6	33	MULTIPLE GESTATION	40	40	0
7	35	OPEN WOUND, ABDOMINAL WALL	6	6	0
8	25	POSTOPERATIVE INFECTION	9	9	0
9	26	MULTIPLE GESTATION	44	44	0
10	32	VAGINITIS	12	12	0
			217	201	16

STATE OF ALASKA
 SKILLED NURSING FACILITIES
 PRECERTIFICATION ACTIVITY
 ACTIVE EMPLOYEE GROUP
 JANUARY 1, 1990 - MARCH 31, 1990

TABLE 16

CASE NUMBER	DIAGNOSIS	ADMISSIONS		DAYS	
		REQUESTED	APPROVED	REQUESTED	APPROVED
1	FRACTURE OF UNSPECIFIED BONE	1	1	17	14
2	FRACTURE OF TUBIA OR FIBULA	1	1	90	33
3	FRACTURE OF TIBIA OR FIBULA	1	1	10	10
4	FRACTURE	1	1	17	14
		4	4	134	71

STATE OF ALASKA
 PER DIEM TRAVEL REIMBURSEMENT
 PROGRAM ACTIVITY REPORT
 ACTIVE EMPLOYEE GROUP
 JANUARY 1, 1990 - MARCH 31, 1990

TABLE 17

CLAIMANT	DATE OF REQUEST	DIAGNOSIS	SURGICAL PROCEDURE CODE	ACCOMPANIED BY PARENT	LODGING EXPENSES	MEAL EXPENSES	TOTAL DOLLARS PAID
MALE EE	11/28/89	CLEFT PALATE W/CLEFT LIP	PALATOPHARYNGOPLASTY	NO	\$130.00	\$52.62	\$72.00
MALE EE	12/01/89	ANAL FISSURE & FISTULA	HEMORRHOIDECTOMY	NO	\$45.70	\$15.25	\$60.95
SON	03/01/90	UNSPECIFIED OTITIS MEDIA	TYMPANOSTOMY	YES	\$160.00	\$90.00	\$111.00
HUSBAND	03/05/90	ABNORMAL BODY TISSUE	EXCISION, TUMOR, THIGH/KNEE	NO	\$90.75	\$0.00	\$80.00
SON	03/20/90	FRACTURE OF FEMUR	TX OF FEMORAL SHAFT FRACTURE	YES	\$43.78	\$24.25	\$0.00
TOTAL					\$470.23	\$182.12	\$323.95

STATE OF ALASKA
CHIROPRACTIC EXPERIENCE
INCURRED CLAIMS
ACTIVE EMPLOYEE GROUP

TABLE 18

CLAIMANT RELATION	NO. OF VISITS	NO. OF CLAIMANTS	VISITS PER CLAIMANT	TOTAL CHARGES	AVERAGE CHARGE PER VISIT	CHARGE PER CLAIMANT	BENEFITS PAID	AVERAGE BENEFIT PER VISIT	BENEFIT PER CLAIMANT
EMPLOYEE	11,579	1,278	9.1	\$354,441	\$31	\$277	\$262,940	\$23	\$206
SPOUSE	6,614	722	9.2	\$190,679	\$29	\$264	\$141,353	\$21	\$196
CHILD	1,987	297	6.7	\$55,835	\$28	\$188	\$38,808	\$20	\$131
1ST QTR 1989 TOTAL	20,180	2,297	8.8	\$600,955	\$30	\$262	\$443,101	\$22	\$193
EMPLOYEE	8,050	1,215	6.6	\$248,378	\$31	\$204	\$157,007	\$20	\$129
SPOUSE	4,468	630	7.1	\$126,421	\$28	\$201	\$73,336	\$16	\$116
CHILD	1,485	275	5.4	\$36,254	\$24	\$132	\$19,433	\$13	\$71
1ST QTR 1990 TOTAL	14,003	2,120	6.6	\$411,053	\$29	\$194	\$249,776	\$18	\$118

NOTE: THIS DATA IS BASED ONLY ON SERVICES INCURRED BETWEEN JANUARY AND MARCH, 1990

STATE OF ALASKA
VISION SERVICE PLAN EXPERIENCE
ACTIVE EMPLOYEE GROUP
JANUARY 1, 1990 - MARCH 31, 1990

TABLE 19

	EMPLOYEE -----	SPOUSE -----	CHILD -----	TOTAL -----
NET BENEFITS PAID	\$199,777.	\$79,621	\$84,167	\$363,565
NO. CLAIM SUBMISSIONS	881	580	695	2,156
AVERAGE COST PER CLAIM	\$226.76	\$137.28	\$121.10	\$168.63

COMBINED AETNA/VISION SERVICE PLAN EXPERIENCE OVER TIME

	1ST QTR. 1989		1ST QTR 1990		% CHANGE -----
	TOTAL -----	VSP -----	AETNA -----	TOTAL -----	
BENEFITS PAID	\$609,741	\$363,565 *	\$81,344	\$444,909	-27%
BENEFITS PER EE	\$47.89			\$33.89	
NUMBER OF EE'S	12,732			13,129	

* VISION SERVICE PLAN DATA IS IMMATURE

DOLLARS PAID BY MONTH:

JAN	\$74,510
FEB	\$123,713
MAR	\$165,342

STATE OF ALASKA
 PRESCRIPTION DRUG PROGRAMS
 UTILIZATION AND COST SUMMARY
 ACTIVE EMPLOYEE GROUP

TABLE 20

	1ST QTR 1989	1ST QUARTER 1990			% DIFFERENCE	
	TOTAL	MAIL ORDER DRUG PROGRAM	AETNA PAR DRUG PROGRAM	INDEMNITY		TOTAL
SUBMITTED EXPENSES	\$860,728	\$40,151	\$200,417	\$573,696	\$814,264	-5.4
BENEFITS PAYABLE	\$657,339	\$39,051	\$179,700	\$505,736	\$724,487	10.2
NUMBER OF PRESCRIPTIONS	16,063	646	9,874	14,300	24,820	54.5
AVERAGE CHARGE PER EE	\$68	\$3	\$16	\$45	\$62	-8.3

STATE OF ALASKA
MAIL ORDER DRUG PROGRAM
JANUARY 1, 1990 - MARCH 31, 1990

TABLE 21

<u># RX PAID</u>	<u>DOLLARS SUBMITTED</u>	<u>DOLLARS PAID</u>	<u>AVG. DAYS SUPPLIED</u>	<u>AVERAGE PAYMENT PER RX</u>
646	\$40,151	\$39,051	67	\$60.45

STATE OF ALASKA
 AETNA PAR DRUG CLAIM PAYMENT SUMMARY
 ACTIVE EMPLOYEE GROUP
 JANUARY 1, 1990 - MARCH 31, 1990

TABLE 22

	NC. RX PAID -----	DOLLARS SUBMITTED -----	DOLLARS PAID -----	AVG. DAYS SUPPLIED -----	AVERAGE PAYMENT PER RX -----
EMPLOYEES	5,358	\$119,028	\$106,883	22	\$19.95
SPOUSES	2,326	\$48,415	\$42,620	23	\$18.32
OTHER DEPENDENTS	2,190	\$32,974	\$30,197	15	\$13.79
TOTAL	9,874	\$200,417	\$179,700	21	\$18.20

STATE OF ALASKA
 AGGREGATE EXPENSE SUMMARY
 FOR DEPENDENTS 19-23 YEARS OLD
 ACTIVE EMPLOYEE GROUP

TABLE 23

KEY INDICATORS	1ST QTR. 1989	1ST QTR. 1990	% CHANGE
GROSS SUBMITTED EXPENSES	\$372,769	\$273,797	-26.6
CLAIM ADMINISTRATION SAVINGS & OTHER NOT COVERED	\$87,303	\$70,791	-18.9
EXPENSES COVERED	\$285,466	\$203,006	-28.9
EXPENSES PAID BY EMPLOYEES			
DEDUCTIBLE	\$21,953	\$14,632	-33.3
CO-PAY	\$20,766	\$10,164	-51.1
TOTAL COST SHARING	\$42,719	\$24,796	-42.0
COST SHARING AS % OF COVERED	15.0%	12.2%	-18.7
COORDINATION OF BENEFITS	\$48,719	\$32,641	-33.0
EXPENSES PAID BY PLAN	\$194,028	\$145,569	-25.0

NOTE: BECAUSE DEPENDENT CENSUS DATA IS NOT AVAILABLE, THE 25% DECREASE REPRESENTS A GROSS REDUCTION IN BENEFITS PAID FOR DEPENDENTS IN THIS AGE GROUP.

STATE OF ALASKA
THIRD PARTY LIABILITY
1/1/90-3/31/90

TABLE 24

CASE #	DATE OF INJURY	TYPE OF CLAIM	DATE OF PAYMENT	AMT OF PAYMENT	THIRD PARTY STATUS	AMOUNT OF RECOVERY	DATE OF RECOVERY
1	01/03/90	MOTOR VEHICLE ACCIDENT	0	\$0.00	0	0.00	0
2	12/15/89	MOTOR VEHICLE ACCIDENT	0	\$0.00	RA-SENT	0.00	0
3	12/30/89	MOTOR VEHICLE ACCIDENT	1/30/90	\$323.00	0	0.00	0
4	12/01/89	MOTOR VEHICLE ACCIDENT	0	\$2,892.89	0	0.00	0
5	12/18/89	MOTOR VEHICLE ACCIDENT	01/04/90	\$1,933.33	0	0.00	0
6	12/10/89	MOTOR VEHICLE ACCIDENT	0	\$0.00	0	0.00	0
7	01/20/90	BASKETBALL	02/28/90	\$14,208.14	PAID	0.00	0
8	01/13/90	MOTOR VEHICLE ACCIDENT	02/07/90	\$307.80	0	0.00	0
9	12/21/89	MOTOR VEHICLE ACCIDENT	0	\$0.00	0	0.00	0
10	01/19/90	UNKNOWN	0	\$22,020.32	RA RECVD	0.00	0
11	12/14/89	MOTOR VEHICLE ACCIDENT	01/18/90	\$436.50	PART PMT	0.00	0
12	01/09/90	NO DETAILS	0	\$2,743.76	PART PMT	0.00	0
13	02/03/90	MOTOR VEHICLE ACCIDENT	02/16/90	\$153.50	PART PMT	0.00	0
14	12/28/89	NO DETAILS	02/16/90	\$267.31	PART PMT	0.00	0
15	12/20/89	SKIING	0	\$1,249.65	NO TPL	0.00	0
16	02/02/90	MOTOR VEHICLE ACCIDENT	0	\$0.00	0	0.00	0
17	12/08/89	MOTOR VEHICLE ACCIDENT	0	\$0.00	0	0.00	0
18	01/11/90	MOTOR VEHICLE ACCIDENT	01/30/90	\$417.00	RA 3/30	0.00	0
19	01/04/90	MOTOR VEHICLE ACCIDENT	0	\$332.05	0	0.00	0
20	02/24/90	MOTOR VEHICLE ACCIDENT	0	\$0.00	AUTO PD	0.00	0
21	03/06/90	MOTOR VEHICLE ACCIDENT	0	\$0.00	0	0.00	0
22	12/01/89	MOTOR VEHICLE ACCIDENT	01/22/90	\$676.50	0	676.50	04/06/90
23	03/02/90	SPORTS INJURY	0	\$0.00	0	0.00	0
24	03/14/90	SPORTS INJURY	03/27/90	\$130.28	NO TPL	0.00	0
	03/14/90	SPORTS INJURY	04/23/90	\$1,473.90	NO TPL	0.00	0
25	03/17/90	SPORTS INJURY	0	\$0	NO TPL	0.00	0
26	01/18/90	UNKNOWN	0	\$483.58	LETTER	0.00	0
27	01/10/90	0	04/11/90	\$180.00	3RD PAID	0.00	0
	01/10/90	0	01/31/90	\$110.00	3RD PAID	0.00	0
28	03/19/90	MOTOR VEHICLE ACCIDENT	04/09/90	\$437.60	0	0.00	0
29	03/24/90	RENAL FAILURE	0	\$706.95	NO TPL	0.00	0
30	03/21/90	MOTOR VEHICLE ACCIDENT	0	\$0.00	TPL SENT	0.00	0
31	03/01/90	UNKNOWN	0	\$0.00	UNINSURD	0.00	0
32	04/02/90	MOTOR VEHICLE ACCIDENT	0	\$0.00	0	0.00	0
33	04/07/90	SNOWMOBILE	0	\$23,114.86	RA SENT	0.00	0
34	03/07/90	MOTOR VEHICLE ACCIDENT	0	\$7,023.10	0	0.00	0
35	04/29/90	MOTOR VEHICLE ACCIDENT	0	\$0.00	0	0.00	0
36	03/31/90	MOTOR VEHICLE ACCIDENT	04/11/90	\$558.60	0	0.00	0
37	02/27/90	MOTOR VEHICLE ACCIDENT	0	\$413.91	0	0.00	0
38	12/29/89	MOTOR VEHICLE ACCIDENT	01/18/90	\$60.58	0	0.00	0

SUMMARY

RECOMMENDATIONS FOR FUTURE REPORTING AND EVALUATION

The methodology and strategy for reporting and evaluating the impact of plan changes on healthcare costs has been developed and presented in this first phase of the project.

We recommend the following strategy throughout 1990 and beyond:

- o that we meet with the State to review the findings of this initial evaluation and to discuss any modifications the State may want in methodology or report presentation.
- o all future reports and evaluation be based on incurred data in order to fully assess the impact of utilization management and plan changes on the State's health care costs.
- o that the next evaluation include all incurred claim experience for the first half of 1990 (January 1 through June 30) and be presented to the State in October, 1990 to allow for sufficient claim lag.
- o that the State may want to consider additional employee communications i.e., newsletter topics, etc., which explain the change in the administration of the coordination of benefits provision.
- o that the State may want to consider the use of employee surveys to monitor the perception of employees to the Utilization Management and plan changes.

We will be prepared to present a proposal for follow up communications during our meetings with the State of Alaska in July, 1990.

INPATIENT PRECERTIFICATION REPORT

GLOSSARY

The numbers preceding the data elements defined here correspond to the column numbers shown on the Precertification Activity report.

1. Certified Confinements

The number of hospital confinements determined to be medically necessary during the report period. When a confinement is certified, one or more hospital days are certified.

2. Denied Confinements

The number of hospital confinements determined to be not medically necessary during the report period. When a confinement is denied, no hospital days are certified.

3. Certified Days

The number of requested hospital days approved during the report period. This number includes recertification days that were approved.

4. Denied Days

The number of requested hospital days approved during the report period. This number includes recertification days that were denied.

5. This Period - Average Length of Certification (ALOC)

The number of certified hospital days approved during the report period divided by the total number of hospital confinements approved for the customer during the report period. (Formula for ALOC: (column 3)/(column 1.)

6. The same Period Last Year - Average Length of Certification (ALOC)

Average length of certification for confinements for the customer for the same report period last year.

7. HEALTHLINE - Average Length of Certification (ALOC)

Average length of certification for confinements for the entire HEALTHLINE program (all HEALTHLINE customers during the report period.

PROCEDURE PRECERTIFICATION ACTIVITY REPORT

GLOSSARY

Total Cases Requested

The total number of procedure precertification and retrospective certification requests received for policyholder during the reporting period.

Total Cases Referred M.D.

The total number of cases referred to M.D. when decision could not be made by nurse.

Total Cases Not Certified

The total number of procedure precertification and retrospective certification requests denied for policyholder during the reporting period.

Percentage Not Certified - This Period

The percent of procedure precertification and retrospective certification requests received that were not certified for policyholder during the reporting period.

Percentage Not Certified - Same Period Last Year

The percent of procedure precertification and retrospective certification requests received that were not certified for policyholder during the same reporting period of the previous year (will be blank this year).

OUTPATIENT PRECERTIFICATION/MANAGED SECOND OPINION REPORTS BY PROTOCOL GLOSSARY

Protocol Procedure

A specific procedure group.

Total Requests

By protocol, the total number of procedure precertification and retrospective certification requests received for policyholder during the reporting period.

Total Denied

By protocol, the total number of procedure precertification and retrospective certification requests denied for policyholder during the reporting period.

% Denied

By protocol, the percent of procedure precertification and retrospective certification requests received that were denied for policyholder during the reporting period.

Total Certified

By protocol, the total number of procedure precertification and retrospective certification requests certified for policyholder during reporting period.

Total Retrospective

By protocol, total number of certifications performed retrospectively for policyholder during the reporting period.

% Retrospective

By protocol, the percent of certifications performed retrospectively.

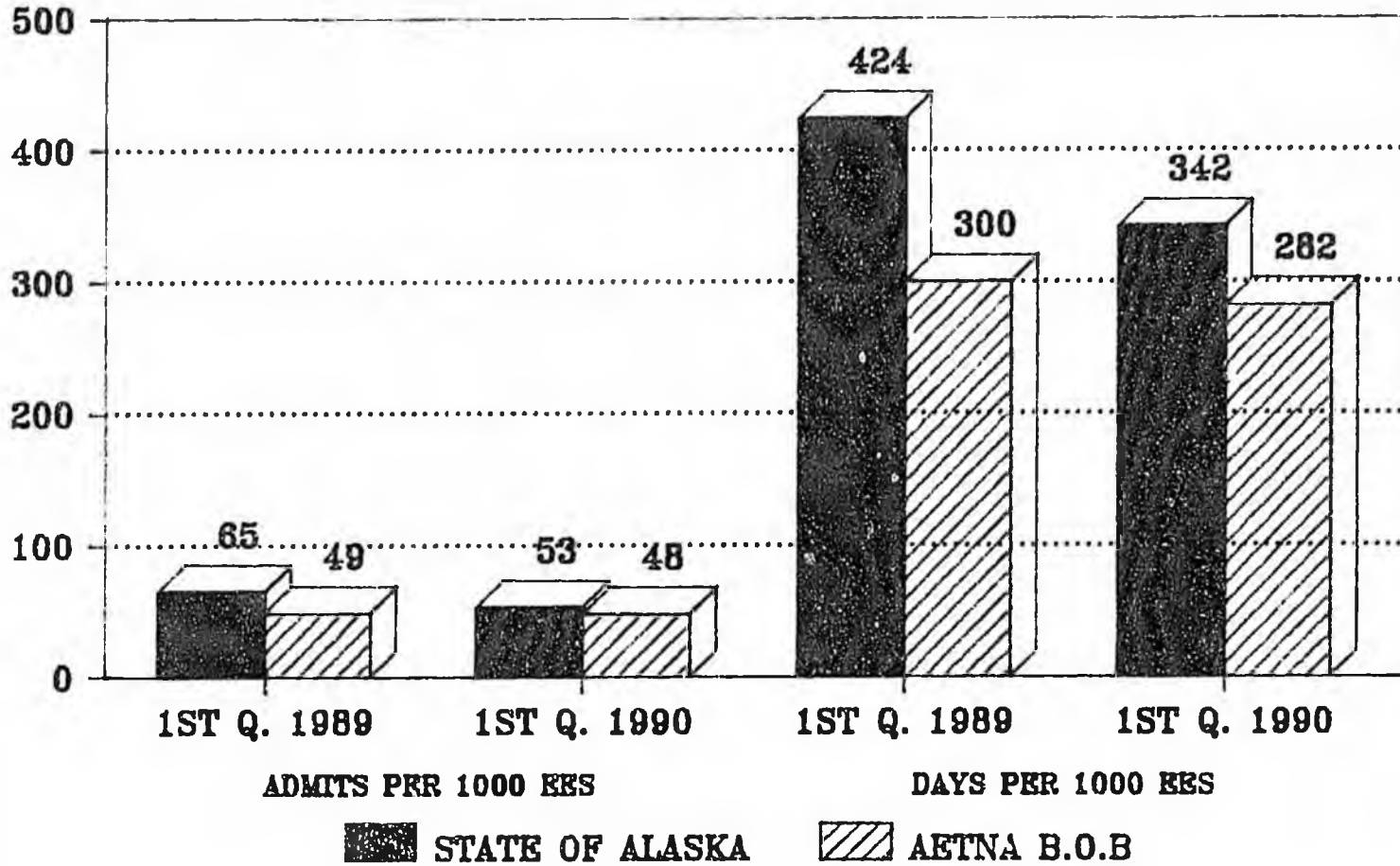
Average Charge per Procedure 1989

By protocol, the average charge per procedure in calendar year 1989.

Estimated Savings

By protocol, the estimated savings to the plan due to averted procedures. (Total denied x average charge per procedure 1989.)

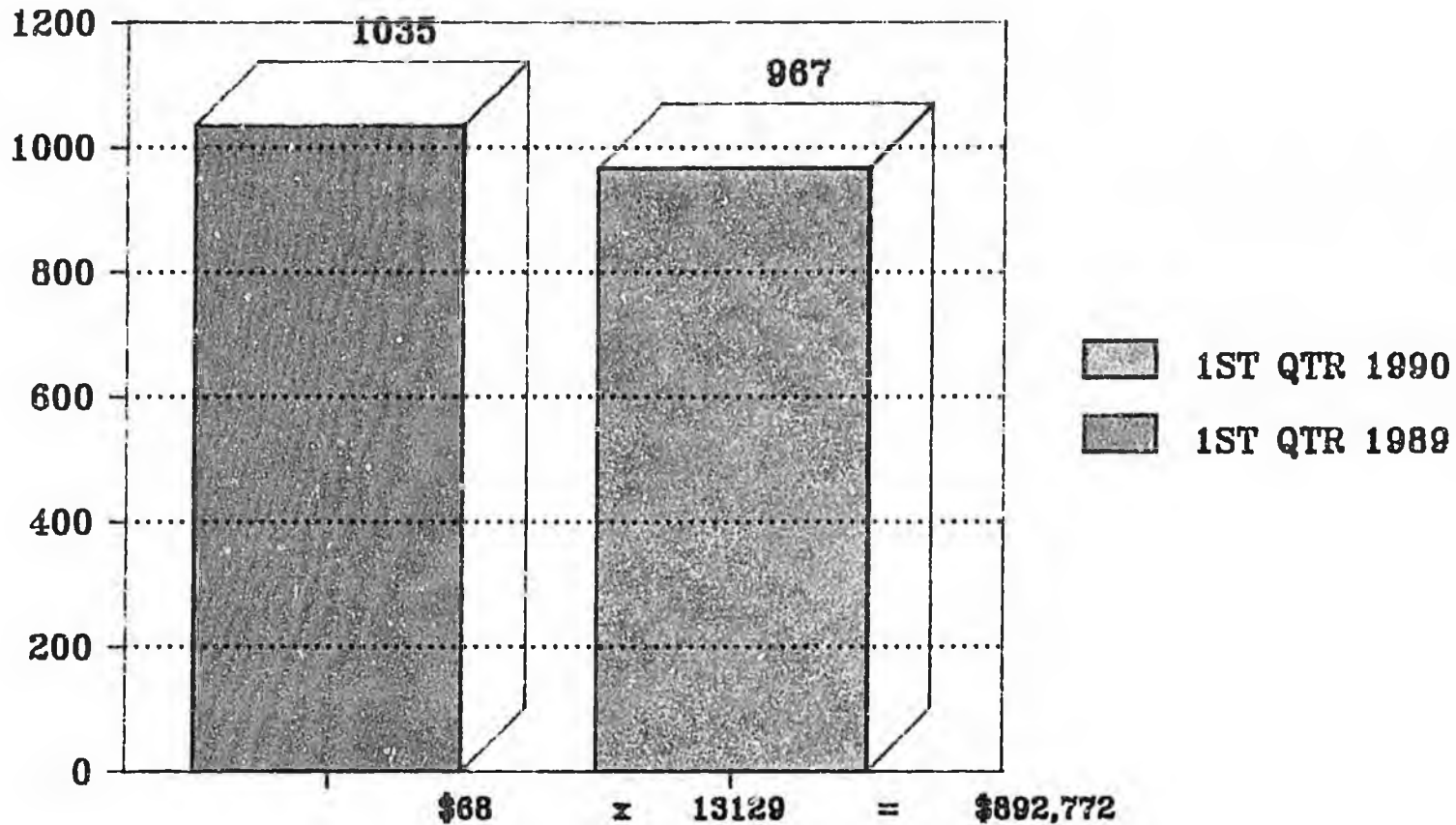
STATE OF ALASKA HEALTHCARE UTILIZATION



Utilization Decrease Data is Aetna B.O.B. Book of Business

(19)

STATE OF ALASKA HEALTHCARE PLAN SAVINGS PER EMPLOYEE



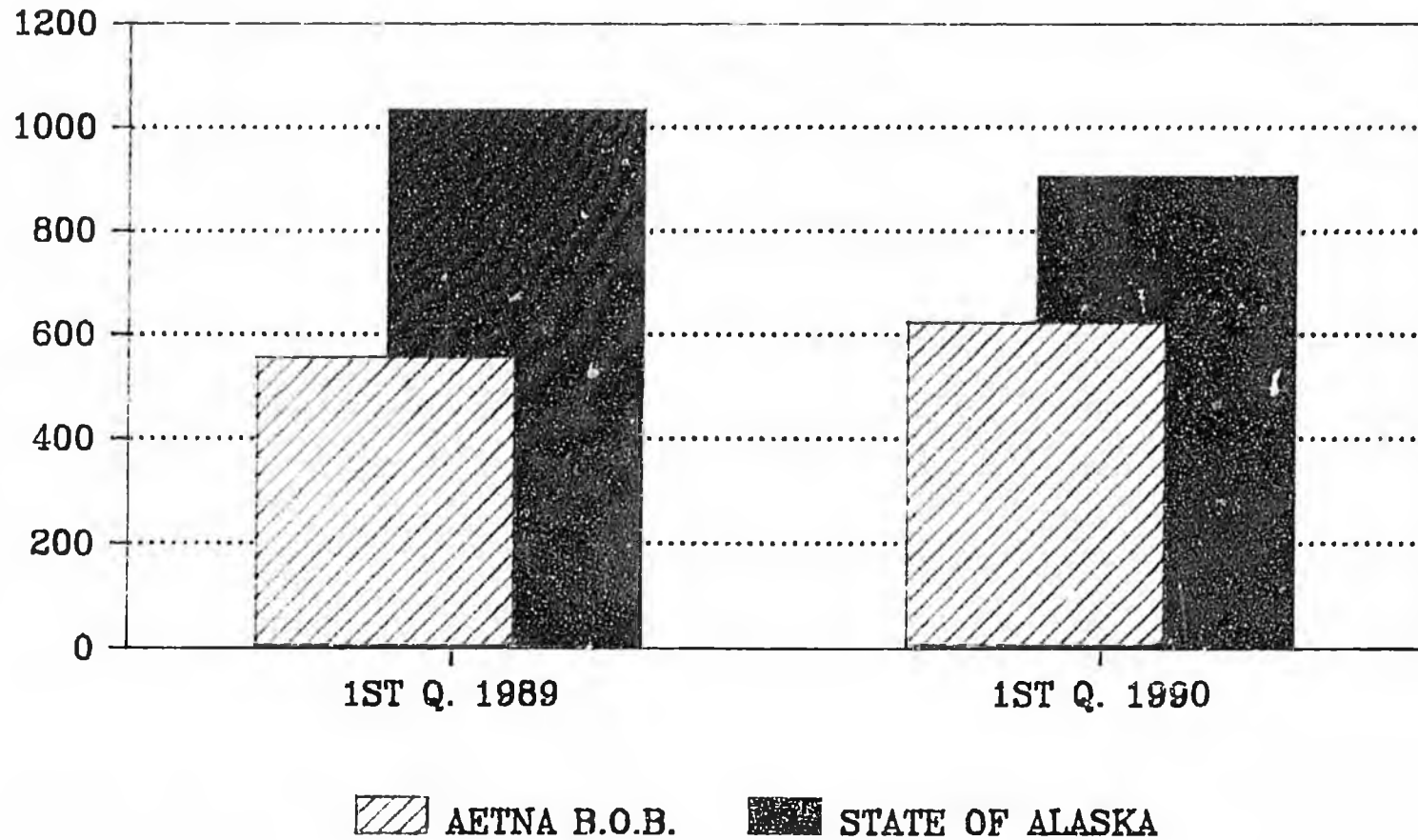
(SAVINGS PER EE) (EMPLOYEES) (1ST QTR 90 SAVINGS)
UNADJUSTED FOR INFLATION

Overall Costs Down

STATE OF ALASKA

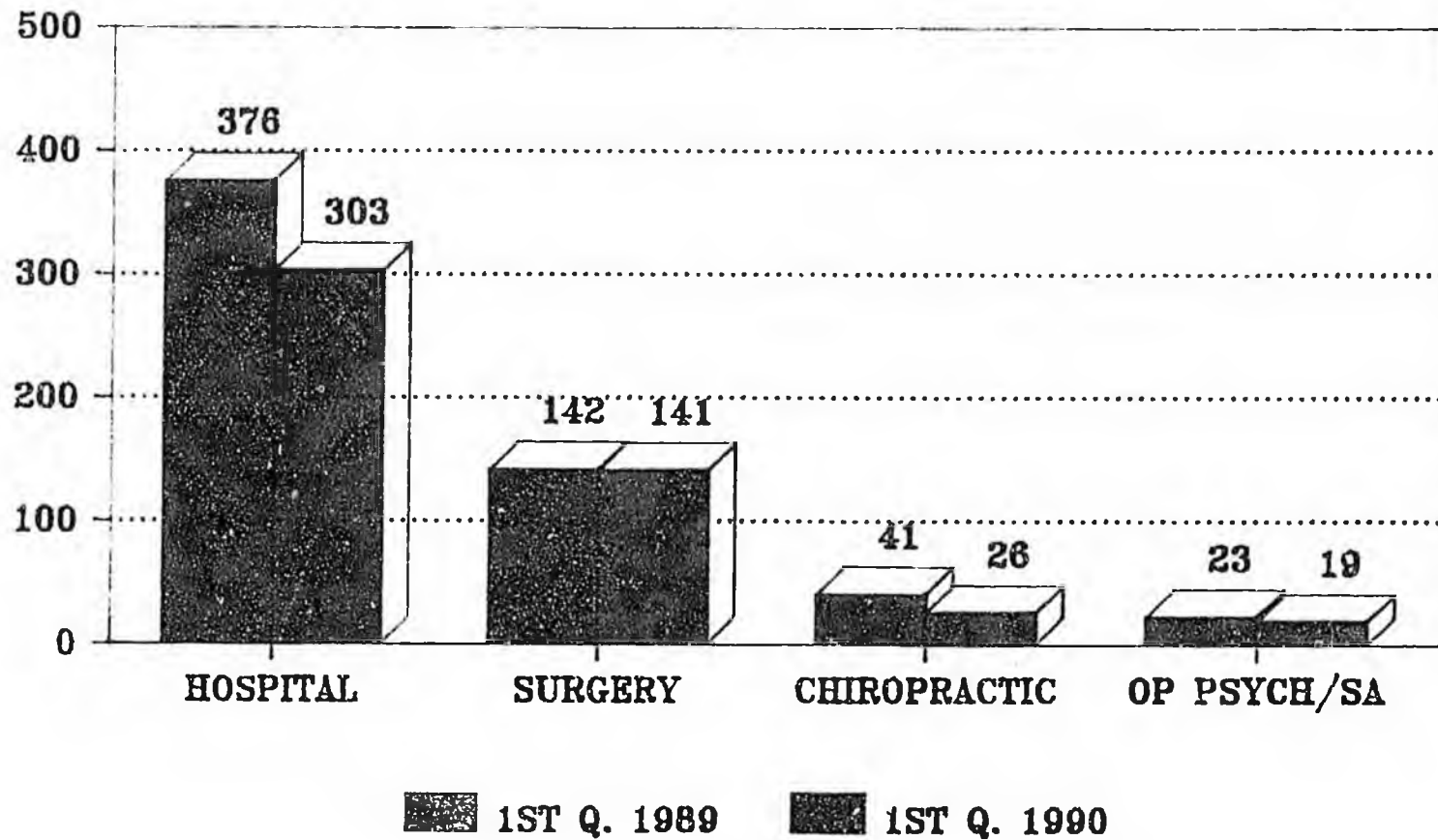
NET PAID PER EMPLOYEE

TREND



STATE OF ALASKA

BENEFITS PAYABLE FOR SELECTED SERVICES PER EMPLOYEE



UTILIZATION MANAGEMENT

EXECUTIVE SUMMARY

Healthline nurses responsible for implementing the utilization management programs have made the following observations. Sample cases presented will provide a view of the rationale for some of the decertifications and/or whether alternate treatment plans were appropriate and utilized.

- o Reports of dissatisfaction and hostility toward the precertification program have reduced significantly. There is a trend towards acceptance of the program, although certain providers remain resistant and uncooperative.
- o Inpatient admissions were averted due to successful intervention of Healthline nurses for outpatient management.
- o Charges for room and board on inpatient confinement that were less than 24 hours duration were waived by the hospitals due to Healthline nurse's intervention.
- o Some surgical procedures were not certified due to the absence or insufficient trial of less invasive treatment plan.
- o Geographic conditions and social issues, e.g., patient lives in a rural area, or far proximity to the hospital are some of the reasons for inpatient confinement.
- o Healthline intervention such as contacting attending physician to request for additional information necessary to determine medical necessity for continued confinement, use of alternate care setting or Home Health Care services have resulted in a discharge.
- o No readmission within 30 days were noted, indicating that early discharges were appropriate.

INDIVIDUAL CASE STUDIES

CASE #1

Patient was scheduled for tonsillectomy, adenoidectomy and insertion of tympanotomy tube. Based on the medical information, adenoidectomy and insertion of tympanotomy tubes were certified. There was no clear indication of performing the tonsillectomy, therefore it was not certified. Attending physician agreed with Aetna medical reviewer to perform the certified procedures only, and will monitor patient's condition if further treatment is necessary after the surgery.

CASE #2

Endoscopy was scheduled for a patient with symptoms of gastric ulcer. After Aetna reviewer contacted the physician, an Upper GI series which is a non invasive procedure was performed.

CASE #3

Precertification for hysterectomy was requested by the patient due to family history of ovarian carcinoma. Attending physician and second examination result confirmed that the primary indication for the surgery is due to patient's request. Surgery was not certified since the patient has no symptoms and evidence of the disease.

CASE #4

Carpal tunnel release was not certified due to non trial of an alternative treatment. Attending physician had recommended the use of splint, but patient had refused this treatment. Attending physician concurred with Aetna reviewer that the use of hand splint will be worth trying first before a more invasive treatment is considered. This was discussed with the patient and was agreeable to the alternative treatment plan.

CASE #5

Patient did not require continued acute care confinement as confirmed by the attending physician. However, he continued to require some skilled nursing services and it will be unsafe to discharge him to home setting without the necessary support in place. On site nurse negotiated with the hospital to reduce charges to skilled nursing facility rate until home health care services were put in place to manage the patient at home.

CASE #6

Inpatient stay was requested on a patient from Sitka, for an outpatient work-up. Healthline nurse informed the patient of a less costly alternative such as the use of Providence House for accommodation at \$34/night.

STATE OF ALASKA
HEALTHY BEGINNINGS PROGRAM
INDIVIDUAL CASE STUDIES

Case # 1

This Nome patient first called saying she couldn't afford food or vitamins. We counselled her on adequate inexpensive foods and found a source in Anchorage that she was able to send away for mail order pre-natal vitamins.

Case # 2

An eighteen-year-old financially unsupported, single, pregnant female currently living with a sibling, required assistance in locating a doctor in the area. Not aggressive in learning about prenatal and newborn care and was not able to get into a childbirth class. We have encouraged her to do as much as possible on her own and have recommended library books, etc. At thirty-four weeks gestation she called us with signs of premature labor. The attending physician told her to go to the hospital, the hospital was telling her to stay home. She called us confused and in pain. We instructed her to go to the hospital. After coaching her through several contractions her labor was stopped at the hospital and we hope for an uneventful outcome.

Case # 8

Patient with hydramnions perceives that the doctor is withholding information. There are no other practitioners in the area. The patient had numerous questions. We developed strategies to improve her communication with her doctor, i.e. ask for longer appointments, make a list of her questions, have the office nurse answer some of the questions. We have reports that the communication has improved.

Case # 30

This patient at twenty-nine weeks gestation had preterm labor which required parenteral tocolytics. We set up a Toco's uterine monitor and home care for medication administration. The patient delivered a healthy baby at full term.

Case 49

Patient with first trimester nausea and vomiting. Discussed options to hospital admission for hydration, i.e. home care, doctor's office. Patient and doctor agree, IV's given at doctor's office periodically allowing her to stay home and care for her other children. This patient also had a urinary tract infection which she refused to treat because she was worried about fetal effects. Education was provided regarding the rationale for antibiotics. She then went ahead with treatment but unfortunately not in time to prevent a miscarriage. If she gets pregnant again she will be a better patient.

STATE OF ALASKA
THE LEGISLATURE

POUCH Y - STATE CAPITOL
JUNEAU, ALASKA 99811
907-465-3800

LEGISLATIVE AFFAIRS AGENCY
LEGISLATIVE REFERENCE LIBRARY

Copies of minutes listed below were originally included in this file. The minutes are available on the STAIRS database CMPR. In order to save space copies of minutes have not been left in the files.

Mary Van Nimwegen

June
?

7/11/90 Health Care Cost Containment Task Force